MEDICARE HMO RISK-CONTRACTOR PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

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ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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MEDICARE HMO RISK-CONTRACTOR PROGRAM

FRIDAY, NOVEMBER 15, 1991

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. The meeting of the subcommittee will please come to order. The purpose of today's hearing is to examine the recent experience of the Medicare beneficiaries who have opted to receive their Medicare benefits as members of health maintenance organizations—HMO's.

I have long believed that the Medicare program should offer beneficiaries the opportunity to enroll in HMO's. I supported the TEFRA amendments in 1982 that authorized Medicare to make this option more widely available. HMO's can provide valuable preventive health care and coordinate services effectively. And, I recognize that many HMO's provide additional benefits and enhanced protection to their Medicare enrollees.

Currently, more than 1.3 million beneficiaries are enrolled in 93 Medicare qualified HMO's. For the most part, I believe these organizations are providing their enrollees access to quality health care.

But there can be abuses. We need to set forth clearly the standards that we expect these organizations to meet—and we should enforce them. Under the law, Medicare HMO risk contractors must: Hold annual open enrollment periods; permit disenrollment with notice; provide assurances of financial solvency; limit Medicare/Medicaid enrollment to 50 percent; cover urgent or emergency services out of area; and meet other quality assurance, payment and marketing standards.

These requirements were included in the law to protect beneficiaries, and to establish appropriate standards for those HMO's that wanted to contract with Medicare. Previous experience with capitated health plans showed that there is potential for underservice, for financial insolvency, for poor quality, and for misleading and overly aggressive marketing.

Recently, the General Accounting Office, GAO, was asked to investigate allegations reported in the Florida press concerning the performance of the Humana Medical Plan, Inc.—a Medicare risk contractor operating in four Florida cities. These press reports claimed that the plan was engaged in prohibited marketing activi-

ties, put its physicians at excessive financial risk, and failed to provide Medicare enrollees opportunities to appeal denials of services provided outside the plan.

We will shortly have the opportunity to hear the results of this GAO investigation and to consider any recommendations that they may wish to offer.

Let me say that I am very disappointed that we continue to encounter problems with the performance of some of the HMO's that have been approved for participation in Medicare. Since it is clear to me that many of these problems are violations of existing statutory requirements, it makes me concerned about the effectiveness and timeliness of HCFA's oversight of this program.

I fear that HCFA's zeal in promoting beneficiary enrollment in HMO's is not matched by its efforts to enforce compliance with our current requirements. I hope that Dr. Wilensky will be able to give us evidence that policies and procedures to enforce the law are in place. It is hard for me to understand why—after almost 10 years since the enactment of TEFRA—that we do not seem to have the capacity or the will to protect Medicare beneficiaries from poorly performing HMO's.

There is no question that HMO's can offer many benefits and advantages to Medicare beneficiaries. There is also little doubt that failure to fully enforce existing patient protection provisions of current law risks the health and safety of some of our most vulnerable citizens.

We must end the uneven and passive administration of this program. I hope today's hearing will mark a turning point in our efforts to assure those beneficiaries who choose HMO's that they may be confident that Medicare risk contractors meet the highest standards in the provision of health care.

I am pleased to welcome to the subcommittee our colleague representative Larry Smith of Florida. Congressman Smith, now in his fifth term, serves on the Foreign Affairs and Judiciary Committees.

He has taken a particular interest in the HMO Medicare program and was one of three members to ask GAO to look into the operation of the Humana health care in his district. I know you have a plane to catch. Your prepared statement will be included in the record.

Without objection, I will leave open in the record the opportunity for any members of the subcommittee to insert an opening statement in the record.

STATEMENT OF HON. LAWRENCE J. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. SMITH. Thank you, Mr. Chairman. I appreciate the opportunity. I want to commend you for not only holding this hearing but for the comments you just made. They echo very much the sentiments many of us in the Congress and my constituents, I can assure you, have on this issue. I would like to thank you for calling this hearing to examine the issues of HMO's and their role in the Medicare risk contractor program.

I am certainly grateful for the opportunity to testify before the subcommittee. Over the past year, Mr. Chairman, we in south Florida have felt a curious sense of deja-vu.

In 1984, my office was swamped with complaints about the International Medical Centers, IMC, HMO, program, and I requested that GAO investigate the situation.

In 1985, the GAO found that IMC's system for coordinating payment to doctors and hospitals was flawed, and that HMO's recording of enrollment and disenrollment dates was inadequate. As a result, both the beneficiaries' and the taxpayers' money was wasted, and those in need were not getting the care they paid for.

People were being told they would not be paid or reimbursed for expenses incurred outside the area, or for emergency visits that had not been previously cleared. As a result, both beneficiaries' and taxpayers' money was wasted and they were not getting the care they were paying for by virtue of the government paying the capitation fee.

In response to this GAO report and these problems, I introduced legislation to tighten HMO regulations, some of which Congress passed in 1987. Yet, just last year, the same problems that we had with IMC seemed to resurface with the Humana Gold Plus Plan, which coincidentally bought the IMC assets from the State of Florida after it went out of business.

The previous owner of IMC, Mr. Reicher, is now closeted in Venezuela having left with millions of dollars.

In October 1990, the Fort Lauderdale News and Sun-Sentinel ran a series of articles on the problems with Humana HMO. Before then and in the subsequent months, my district office received numerous complaints validating the articles in the Sun-Sentinel.

In November 1990, I asked the GAO to look into the problems and complaints many of my constituents raised against the Humana Gold Plus Plan. As Janet Shikles of the GAO will testify, some of the things the GAO looked into were: Humana's enrollment practices, payments for medical care, and quality of medical care to elderly beneficiaries.

The GAO has conducted an extensive study of the Humana Gold Plus Plan and HCFA's oversight of the plan, and the GAO investigators will give the subcommittee their technical findings and document Humana's and HCFA's inadequacies. But this morning, I would like to share with you some specific examples of the breakdown of this HMO system and the heartbreak it has brought.

One case in my district is Mrs. Hazelfern Lentz, who was signed up for Humana Gold Plus Plan without her consent. A Humana sales agent visited her, but she was not interested in joining the plan because she wanted to keep her own doctor under the Medicare program. The sales agent wrote down her Social Security number and said he would keep it on file and talk with her again.

A few months later Mrs. Lentz was mugged at a mall. She underwent surgery and physical therapy for her shoulder, but when she sent the bill to Medicare, it was rejected. Without her authorization, she had somehow been signed up for the Humana Gold Plus Plan, thus losing her Medicare coverage.

Mrs. Lentz immediately reported the issue to State insurance investigators. However, despite the inquiry, the hospital handed her

case over to a collection agency. Before Humana agreed to disenroll her, Mrs. Lentz was forced to sell a diamond necklace that had belonged to her great-grandmother to pay her doctor bills. Humana later admitted that the signature on her enrollment card had been forged.

Another Floridian, Mrs. Barbara Walter, contacted me to describe the anguish she and her husband experienced with Humana. Mrs. Walter's mother-in-law suddenly was unable to walk or swallow, and was totally incontinent. She was diagnosed by Humana Gold Plus doctors as having a "low potassium level."

Mrs. Walter demanded further tests for her mother-in-law, but, unfortunately, her mother-in-law passed away while waiting over a month for her appointment on the tests.

In another case, according to the Sun-Sentinel, Mrs. Lena Formica joined the Gold Plus Plan expecting quality care. After joining the program, Mrs. Formica was told that she soon would receive materials about the plan she had just signed up for. One month later her husband fell ill with a severe fever and the shakes.

Since the Formicas had not received the information about the plan or identification cards, Mrs. Formica assumed that they were still covered by Medicare. She then presented the hospital with her Medicare identification. As her husband's health improved they were told by home health aides that they were not covered under Medicare. Humana would not take responsibility for the bills because they were not informed ahead of time that Mr. Formica was going to be under care. The family was left to struggle with nearly $6,000 in unpaid bills.

Mrs. Joann Rhind also contacted my office. Mrs. Rhind suffered from chronic urinary infections. She called to make an appointment with her primary physician and was told there was a 3-week wait. Then, she resorted to an "urgent care" appointment. The doctor examined Mrs. Rhind and told her she needed to see a urologist, but, according to Mrs. Rhind, the doctor said, "she would be in dire trouble, from Humana, if she okayed it."

In Broward County, Fla., Humana doctors collect $477 a month from the Federal Government for each person enrolled in the Humana Gold Plus Plan.

This runs to three-quarters of a billion dollars a month in my area alone. The primary care doctor must see the patient first and then decide whether the patient needs to see a specialist. Mrs. Rhind's physician thought her case warranted a specialist's opinion.

However, it appears her case was not grave enough for the Humana physician to actually pay the specialist—out of Mrs. Rhind's $477 monthly medical allowance—for an appointment.

Mrs. Dorothy Barrett, actually did choose to join the Humana Gold Plus Plan. In early 1989, Mrs. Barrett noticed serious bleeding and went to her Humana Gold Plus Medical Center. She was diagnosed first with hemorrhoids, and then, when the bleeding persisted, with an irritable bowel. Four months later, Mrs. Barrett woke up to find blood trickling down her legs. The Humana Gold Plus Medical Center performed a variety of perfunctory tests and did not find a critical illness.

Fearing that she was getting the cheapest rather than the best medical care, Mrs. Barrett quit the Gold Plus Plan and sought a new private doctor. This new doctor diagnosed Mrs. Barrett's problem as colon cancer and recommended immediate surgery. Humana later acknowledged its negligence, but Mrs. Barrett is convinced that it was a financial decision and not a medical oversight.

As the GAO will testify, Humana has made many of these so-called "financial decisions" like they did in Mrs. Barrett's case.

These five cases are just a sample of the dozens of calls my office has received over the last year. These calls, and the Sun-Sentinel articles, prompted me to request the GAO investigation, which found many of the allegations to be true.

GAO found that Humana refused to pay claims for emergency or urgently needed services that occurred outside the "Humana service area." Denying payment for emergency claims is a violation of Medicare regulations. Does the Humana Corporation expect a person to arrange to have a heart attack on the steps of a Humana hospital?

GAO also found that Humana did not treat complaints from beneficiaries or denials of payment as the law requires. Federal regulations require an HMO to send a case not resolved in the beneficiary's favor to HCFA for final adjudication. Humana has 60 days to take action.

According to the GAO, HCFA knew that Humana was not complying with these regulations. But HCFA looked away, depriving beneficiaries of their appeal rights.

The question before this subcommittee and the Congress is: What can be done to prevent disasters like these from occurring in the future? We thought we had fixed it once.

The most obvious answer is that HCFA needs to issue the regulations dictated by Congress and act as an advocate for the beneficiaries, rather than as a salesman for the HMO's. HCFA must make sure that violators of Federal regulations are punished. If not, HMO beneficiaries will continue to be penalized by a lack of quality care and also incur serious disabilities.

As part of the 1987 Omnibus Reconciliation Act, HCFA was granted the authority to impose intermediate sanctions on noncompliant HMO's. HCFA has yet to issue the final regulations necessary to empower this authority and instead, as the GAO documents, let Humana enroll 125,000 new beneficiaries in the Gold Plus Plan while Humana was not complying with Federal law. This is the 1987 Omnibus Reconciliation Act; this is now 1991.

As the subcommittee has witnessed in its regulation battles over the Clean Air Bill and Medicaid, the administration has either been slow to issue regulations for laws Congress passed, or issued regulations too lenient to comply with congressional intent. This is not just a philosophical battle between two branches of the government. As the Humana scandal shows, this is executive negligence that has a real impact on people's lives and health.

This negligence can be clearly seen in a December 1990 internal HCFA memo obtained by the GAO for its March 1991 report on Medicare HMO's and quality assurance. In the memo, HCFA stated:

Our priority up to now has been to promote enrollment in HMO's and we have not given equal priority to monitoring what happens to beneficiaries after they have enrolled.

Congress authorized HCFA to oversee HMO programs, not to drum up business for these private medical companies. This type of memo is disgraceful. It abrogates the charge from Congress that HCFA is meant to discharge.

The elderly and the sick are some of the most vulnerable members of our society. I fear that political pressure may be preventing HCFA from fulfilling its responsibilities to Medicare beneficiaries that enrolled in HMO's. Too much money and too many lives are at stake. Seven hundred and fifty million dollars a year is being paid to them by taxpayer, including people who are the beneficiaries. I will continue to work, hopefully, with this subcommittee.

And I know the hallmark of your career, Mr. Chairman, has been concerned with resolving these problems, to work with you and others to find ways to compel HCFA and HMO's to fulfill its mandate on behalf of those in need. We must prevent disasters like the Humana Gold Plus Plan from happening in the future. One deja-vu is enough, Mr. Chairman.

Thank you.

Mr. WAXMAN. Thank you, Mr. Smith.

I want to commend you on an a excellent statement and your aggressive actions to try to keep this kind of scandal from happening over and over again.

We do have to rely on the Health Care Financing Administration to do its job.

We have given them the tools, the ability to come in and supervise and give sanctions against those HMO's that are abusing, either their marketing, or the care for the Medicare patients to whom we promised, as a Nation, that they would be protected for health care costs in the years that they are eligible for those services.

We do want to work with you.

We are looking forward to hearing from the other witnesses and then trying to figure out what more we need to do to make sure that people are not subject to this kind of abuse.

Mr. SMITH. Well, Mr. Chairman, I look forward to working with you. With constituents like mine, with about 25 percent of the constituents on Social Security and many of them on Medicare, they are looking to Washington to find answers to these terrible problems which beset them.

I have never been opposed to HMO's. I know you also want to find the broadest range of Medicare options available to provide medical care at the lowest cost to the government.

We have all been looking for that. HMO's have been chartered by the Federal Government to provide such care.

The problem is we cannot be seen as a Nation to make sure what we said we wanted was actually delivered to the constituents. And we cannot allow these dangerous types of situations to continue.

If HMO's can work, they should. People will have an option to provide them with the standard care of a doctor or a HMO, or PPF, or any kind of provider service that may be available for health care.

But, Mr. Chairman, if we are going to do anything to protect them, everybody must deliver quality care. We cannot demand anything less of the people, not only because they are getting taxpayer money, but because the people deserve nothing less.

I thank you very much.

Mr. WAXMAN. Thank up very much for being with us.

Our next witness is Janet L. Shikles, Director of Health Financing and Policies Issues, GAO. She supervises GAO efforts to verify problems reported about the medical planning in Florida, and to determine whether HCFA efforts in these problems were effective.

We are pleased to welcome you this morning.

Your prepared statement will be part of the record in full. We would like to ask you to deliver your oral presentation in no more than 5 minutes.

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ED STROPKO, ASSISTANT DIRECTOR

Ms. SHIKLES. Thank you, Mr. Chairman.

I would like to introduce my colleagues, Ed Stropko and Peter Schmidt.

I am pleased to be here today to discuss our review of Federal efforts to address violations of the Medicare requirements at the Humana Plan in Florida. Recently, concerns over Federal oversight of HMO's were rekindled by press articles alleging widespread problems with Humana Medical Plan, the largest HMO contractor.

Our review illustrates, as did our prior work on this subject, that HCFA has not been effective in getting certain HMO's to take corrective actions promptly. The continued violations of Medicare requirements by the Humana Medical Plan, demonstrates HCFA's unwillingness and inability to enforce Medicare requirements on HMO's serving Medicare beneficiaries.

Although we have determined HCFA looked at the problems identified in the press, they have not resolved the problems in 3 years of effort. Specifically, HCFA found Humana Medical Plan to be violating Federal standards related to four areas: marketing, claims payment. processing of beneficiary appeals, and implementation of an internal quality assurance system.

We found the Humana plan violated marketing, claims payments, processing of beneficiary appeals and implementation of an internal quality assurance system. I will touch on each.

The first involves marketing practices, Humana Medical Plan violated Medicare requirements for 2½ years. Actually, HCFA expressed internal concerns about marketing problems in 1987, but did not cite the Humana Medical Plan for violating Medicare standards in this area until 1989. At that time, HCFA found the plan to be violating the requirement to provide members with current information on the plan's rules, benefits and costs.

Violation of this requirement can result in costly misunderstandings in which enrollees could incur charges for expensive medical services that are not covered by the HMO plan.

Inappropriate denial or delayed payment of claims is another area where HCFA has found problems for 3 years. These problems have not yet been fully corrected.

In three site visits since 1989, HCFA found the medical plan denied certain claims for inappropriate reasons. The plan refused to pay claims for emergency services and urgently needed services obtained outside the plan's service area because they with had not been authorized in advance. This is a violation of the Medicare regulations.

The effect of this on beneficiaries can be significant. For example, in one case, a Medicare enrollee was admitted to a hospital on an emergency basis. On the grounds that this admission had not been authorized by a Humana plan physician, Humana refused to pay for the bill. This left the beneficiary with a $24,000 hospital bill.

The hospital eventually appealed to HCFA to intervene, and 16 months after the beneficiary was discharged, the Humana plan changed its mind and then paid for the hospital bill.

A third problem involves Humana Medical Plan's process for beneficiaries to appeal claims. Medicare has established specific criteria and time frames HMO's must meet for handling beneficiary appeals. HCFA found the Humana Medical Plan did not follow these requirements. In 1991 a HCFA monitoring report specifically noted the similarity between the beneficiary appeals deficiencies found in 1991, and those found in 1989.

Quality assurance is another area where HCFA found violations. In 1989, they found the Humana Medical Plan did not collect enough ambulatory care data to systematically identify physicians with patterns of underservice to Medicare enrollees. The plan did not resolve this problem until 2 years after HCFA requested corrective action. HCFA was particularly concerned about the lack of data on physicians' service patterns because of an inherent incentive for Humana Medical Plan affiliates to underserve the plan enrollees. This is because the plan passes on a significant portion of the financial risks it assumes from Medicare.

In conclusion, we believe HCFA should have done more to require Humana Medical Plan to resolve its deficiencies. Deficiencies in the areas that I have described can mean that beneficiaries incur high out-of-pocket costs or are denied appropriate care. In light of these consequences, we believe that to allow the Humana Medical Plan to enroll over 125,000 new beneficiaries during this period was unreasonable.

To help prevent the recurrence of sustained deficiencies, HCFA needs to unequivocally establish both its authority and intention to take timely action against HMO's that violate Medicare's minimum safeguard standards.

Mr. Chairman this concludes my statement.

I will be pleased to take any questions.

[Testimony resumes on p. 20.]

[The prepared statement of Ms. Shikles follows:]

STATEMENT OF JANET L. SHIKLES

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss our recent review of federal efforts to address violations of Medicare requirements at the Humana Medical Plan, Inc., which is located in Florida.[1] Recently, concerns over federal oversight of Health Maintenance Organizations (HMOs) were rekindled by press articles alleging widespread problems with Humana Medical Plan, which is Medicare's largest HMO contractor. The articles reported allegations of marketing and claims payment abuses by this contractor and also problems relating to its quality of care.

In light of these allegations, congressional requesters[2] asked us to review the actions of the Health Care Financing Administration (HCFA), which is responsible for overseeing HMOs serving Medicare enrollees. Specifically, they asked us to ascertain whether HCFA had identified the problems alleged by the press and whether HCFA's actions to resolve problems at Humana Medical Plan were prompt and effective.

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[1]Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

[2]Fortney H. (Pete) Stark, Chairman, Subcommittee on Health, House Ways and Means Committee, and Representatives Lawrence J. Smith and E. Clay Shaw.

RESULTS IN BRIEF

Our review illustrates, as did our prior work on this subject, that HCFA has not been effective in getting certain HMOs to take corrective actions promptly. The continued violations of Medicare requirements by Humana Medical Plan demonstrates HCFA's unwillingness and inability to enforce Medicare requirements on HMOs serving Medicare beneficiaries.

Although we determined that HCFA verified the problems identified in the press, HCFA has yet to resolve all the problems after nearly 3 years of effort. Specifically, HCFA found Humana Medical Plan to be violating federal standards related to four areas: marketing, claims payment, processing of beneficiary appeals, and implementation of an internal quality assurance system. Deficiencies in these areas can mean that beneficiaries incur high out-of-pocket costs or are denied appropriate care. In light of these consequences, we believe that allowing Humana Medical Plan to enroll over 125,000 new beneficiaries during its protracted period of noncompliance was unreasonable.

HCFA can and should have done more to require Humana Medical Plan to resolve its deficiencies. To help prevent the recurrence of sustained deficiencies, HCFA needs to unequivocally establish both its authority and intention to take timely and decisive

action against HMOs that violate Medicare's minimum beneficiary safeguard standards.

BACKGROUND

At this point, let me provide some background about this program. About 4 percent (1.4 million) of the nation's 33 million Medicare beneficiaries are enrolled in federally qualified risk HMOs. Such HMOs contract with HCFA to provide health care in return for a predetermined monthly payment per enrollee. HCFA typically makes site visits to these HMOs to monitor their compliance with Medicare requirements. If an HMO that is out of compliance does not carry out required corrective actions, HCFA can terminate the HMO's Medicare contract or, in some cases, suspend enrollment of additional Medicare beneficiaries or impose monetary penalties.

Humana Medical Plan accounts for about 15 percent of all Medicare beneficiaries enrolled in risk HMOs nationwide. Most of the health care provided by Humana Medical Plan is provided by subcontractors called affiliated providers. These affiliated providers are independent physicians or group practices. Because the Humana plan pays them a fixed amount per enrollee to provide health services, in many respects the affiliated providers operate like small HMOs.

Now, let me discuss in more detail the four problem areas HCFA identified at Humana Medical Plan.

MARKETING PRACTICES WERE
A HCFA CONCERN

The first area involves marketing practices. Humana Medical Plan violated Medicare requirements in this area for 2-1/2 years. HCFA first expressed internal concerns about marketing abuses in 1987, but it did not cite the Humana Medical Plan for violating Medicare standards in this area until 1989. At that time, HCFA found the plan to be violating the requirement to provide members with current information on the plan's rules, benefits, and costs. Violation of this requirement can result in costly misunderstandings in which, for example, enrollees could incur charges for expensive medical services that are not covered by the HMO plan.

In early 1990, marketing practices at another HMO owned by Humana led HCFA to investigate marketing practices at five of the six Medicare risk plans that Humana owns. The investigation led HCFA to characterize Humana as having a corporate philosophy of aggressive and manipulative marketing practices.

According to HCFA, this philosophy was expressed most explicitly in Humana's corporate marketing training manual, which

recommended, for example, that marketing agents employ a tactic called the "kleenex close." This tactic involves obtaining the enrollment of reluctant customers by manipulating them to gain their sympathy. Marketing agents who fail to make a sale remark to their customers, upon leaving, that their livelihood depends on these sales and that they need to learn from the experience of losing a sale. They ask the customer to specify what information was not properly covered so that they can avoid repeating the mistake in the future. The agent is then advised to " . . . cover it and close [the sale]!" HCFA requested that Humana revise its marketing guidance to eliminate these practices.

In October 1991, HCFA reported Humana Medical Plan in compliance with marketing requirements.

HCFA IDENTIFIED RECURRING
PROBLEMS WITH PAYMENT OF CLAIMS

Inappropriate denial or delayed payment of claims is another area where HCFA found problems over the last 3 years. These problems at Humana Medical Plan have not yet been fully corrected.

In its three site visits since 1989, HCFA found that Humana Medical Plan denied certain types of claims for inappropriate reasons. The plan refused to pay claims for emergency services and for urgently needed services obtained outside the plan's

service area because the plan had not authorized the services in advance. Denying payment for such claims is a violation of Medicare regulations. The regulations require risk HMOs to pay for services delivered outside the HMO's service area if they meet Medicare's criteria for emergency or urgently needed services. HCFA found in 1991 that the plan's affiliated providers were still denying payment for the physician portion of some emergency hospital stays, even though the plan had approved payment for the hospital portion.

The effects of this on beneficiaries can be significant. For example, in one case, a Medicare enrollee was admitted to a hospital on an emergency basis. On the grounds that this admission had not been authorized by a Humana plan physician, the Humana plan refused to pay for it. This left the beneficiary with an unpaid $24,000 hospital bill. Eventually, the hospital asked HCFA to intervene, and 16 months after the beneficiary was discharged, the Humana plan reversed its position and paid for the admission.

Though inappropriate denials such as this are a serious problem, HCFA has not developed standards that define the percentage of inappropriate denials it will tolerate. Without such standards, HCFA determined that it could not consider the HMO as violating a Medicare requirement. Concerned about this problem, HCFA is now beginning to develop such standards.

In addition to inappropriate denials, HCFA has also found Humana Medical Plan to be slow in paying its bills. Since early 1989 HCFA has continued to find that some of the plan's affiliated providers fail to pay bills within required time limits for services given by outside providers.

HCFA HAS NOT FORCED HUMANA PLAN TO CORRECT VIOLATIONS IN HANDLING BENEFICIARIES' APPEALS

A third problem involves Humana Medical Plan's process for beneficiaries to appeal claims. Medicare has established specific criteria and time frames that HMOs must meet for handling beneficiary appeals. Medicare regulations also require HMOs to send cases not resolved in the beneficiary's favor to HCFA for a final decision. HCFA found that Humana Medical Plan did not follow these requirements. Specifically, when beneficiaries complained that the plan inappropriately denied their claims, the plan did not always treat these complaints as Medicare appeals. This treatment has the effect of denying beneficiaries their right to appeal to HCFA. In fact, these beneficiaries may find themselves liable for large medical bills with recourse only through the courts, which many may find too costly and unfamiliar to use. A 1991 HCFA monitoring report specifically noted the similarity between the beneficiary appeals deficiencies found in 1991 and those found in 1989.

HCFA AWARE OF PERSISTENT
PROBLEMS WITH QUALITY ASSURANCE

Quality assurance is another area where HCFA found violations. In 1989 HCFA found that Humana Medical Plan did not, as regulations require, collect enough ambulatory care data to systematically identify individual physicians with patterns of underservice to Medicare enrollees. The plan did not resolve this problem until 2 years after HCFA requested corrective action.

Medicare's system of paying HMOs encourages them to be cost conscious. They are paid a predetermined rate per enrollee, and HMO providers may strive not to exceed the fixed amount by "underserving," or providing fewer services to enrollees than are necessary. The Florida Peer Review Organization has found instances of such underservice at Humana Medical Plan. Since 1987 the Organization has identified at least 35 physicians with patterns of underservice to Medicare enrollees. These patterns included failure to order appropriate diagnostic tests and failure to follow up on abnormal test results.

HCFA was particularly concerned about the lack of data on physicians' service patterns because of an inherent incentive for Humana Medical Plan affiliates to underserve Medicare enrollees. That is, Humana Medical Plan passes on to its affiliated providers

a significant portion of the financial risks it assumes from Medicare. Specifically, the affiliates are at risk for 50 percent of losses incurred for hospital inpatient care (subject to a $20,000 dollar per hospitalization stop loss provision) and 100 percent of losses incurred for outpatient primary care. In its 1989 site visit report, HCFA said these arrangements made it imperative that Humana Medical Plan develop a system to routinely monitor primary and specialty ambulatory care services.

HCFA'S EXISTING SANCTION
AUTHORITY REMAINS UNUSED

Lastly, I would like to discuss HCFA's authority to impose sanctions on HMOs that fail to comply with Medicare requirements. Almost 4 years have passed since the Congress gave HCFA the authority to impose intermediate sanctions that are less drastic than contract termination. Under the 1987 Omnibus Budget Reconciliation Act, HCFA may assess civil monetary penalties or suspend the enrollment of Medicare beneficiaries. HCFA officials have been reluctant to use this authority because final regulations have not been issued. Draft regulations were published for comment about 4 months ago. However, even when final regulations are published, HCFA's use of the intermediate sanctions may be impeded by a lack of policy guidance on the types of circumstances that warrant the sanctions. Lack of such policy guidance has already been a source of conflict between regional and

final regulations are published, HCFA's use of the intermediate sanctions may be impeded by a lack of policy guidance on the types of circumstances that warrant the sanctions. Lack of such policy guidance has already been a source of conflict between regional and headquarters HCFA personnel. Consequently, HCFA needs to formulate such policy guidance.

As we reported in 1988 and in 1991, HCFA's authority to impose intermediate sanctions does not apply in every circumstance under which an HMO might be violating Medicare requirements.[3] The sanctions apply when an HMO fails to pay provider bills in a timely fashion, fails to provide required medically necessary items and services, or misrepresents or falsifies information provided to the Secretary or to other individuals and entities.

We recommended in 1988 that Congress consider giving HCFA broader authority so that HCFA could more easily apply intermediate sanctions. Specifically, we recommended that HCFA be given greater discretion to suspend Medicare enrollments in HMOs that, for whatever reason, fail to respond to notices concerning violations in a timely manner or have recurring deficiencies.

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[3]Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 1988); Medicare (GAO/HRD-92-11, Nov. 12, 1991).

CONCLUSIONS

In conclusion, the Humana Medical Plan case illustrates that HCFA has not yet corrected the longstanding problems it has in obtaining corrective action from HMOs. To become more effective, we believe HCFA should take two actions. Specifically, HCFA should

-- adopt policies for determining the circumstances that warrant intermediate sanctions, and

-- develop a standard for HMOs that would specify an acceptable performance rate for paying claims.

Lastly, broadening HCFA's sanction authority along the lines that we recommended in our 1988 report could help avert future problems by making any violations of Medicare requirements by an HMO subject to intermediate sanctions.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

Mr. WAXMAN. Thank you for your presentation to us on the work that you have done in this investigation.

Do you have any investigative opinion about how widespread the problems you identified in Florida may be?

Ms. SHIKLES. No. We focused on the Humana-Florida situation. But the problems we identified, marketing abuses and quality issues, are problems we have identified in previous reviews. That is why we are very concerned that HCFA has not put in place a very good monitoring program, so that when it finds a problem, it quickly takes action and gets it fixed.

Mr. WAXMAN. With the understanding that there are Medicare beneficiaries enrolled in HMO's all across the country, and since we don't expect, given the performance of HCFA in this situation in Florida, that they are doing much better in policing to make sure that the regulations are lived up to by these HMO's, we may well expect that other people around the country who are in Medicare HMO's might be facing the same kinds of problems; correct?

Ms. SHIKLES. Yes. I think the HCFA regional offices are concerned about that issue. That is, that they don't have a good monitoring system in place, and if there were problems, they may not know about it, and they would not be able to take action quickly. Several HCFA regional offices wrote the HCFA administrator about this a year ago.

Mr. WAXMAN. You testified that not only has HCFA failed to publish information implementing regulations for the intermediate sanctioning authority that Congress granted in 1987, they also have not presented policy guidelines about when and under what circumstances sanctions should be applied.

Do you know what has caused their reluctance to use these tools?

Ms. SHIKLES. We have no understanding why it has taken so long. When Congress gave the authority in 1987, it was after the IMC scandals. Various scandals occurred.

We don't understand why HCFA did not take immediate action. We don't understand why they took 4 years to come out with regulations that are very straightforward, very much like the legislation. We have no understanding of why it takes so long.

Mr. WAXMAN. Do you have a opinion of the regulations under OBRA 1990, of the risks that should be imposed on these situations in HMO's?

Ms. SHIKLES. We are very concerned about that, particularly in the Humana Medical Plan situation where the outpatient care is transferred to physicians. If you have that situation, at least you should have safeguards in place.

Yet the way the affiliated providers operate, there are no safeguards. They operate like mini-HMO's but they don't have to meet Federal standards. We have so much financial risk to small entities, we think it is really scary.

Mr. WAXMAN. What kind of standards would you want them to have in place, assuming the risk has shifted to a panel of doctors carrying the full financial risk? If they are going to start providing more financial services to a patient and, therefore have a disincentive to provide those services, what should we do to see what they are doing?

Ms. SHIKLES. We have raised concerns in the past about shifting that much risk to a small number of doctors that may serve a small number of beneficiaries. You can shift the risk if it goes to a large panel of physicians and a large panel of enrollees.

In the Humana case, each time an enrollee goes to the physician, the physician is at risk for every outpatient service, and up to $20,000 on inpatient services that are diagnosed for a patient. I think if I was a patient, I would be concerned that the physician may think twice about referring me to a specialist because that is going to come out of his pocket. The Humana plan is unusual.

Ed, do you want to add to it?

Mr. STROPKO. I think the Humana network model is fairly unique but there are some others similar to it. What we were looking for the last 4 or 5 years is if these network kinds of models are permitted to exist, there needs to be Federal oversight and requirements that the affiliates required to meet regarding minimum enrollment and financial solvency. They are franchises, like mini-HMO's.

Mr. WAXMAN. It seems you have some concern that doctors carrying that financial risk may not be able to bear it and will go out of business and leave the Medicare beneficiaries holding the bag?

Mr. STROPKO. Really, you don't want to receive care from somebody who could lose large sums of money in providing that care. The problems are exacerbated if the entity is in financial trouble to begin with.

Mr. WAXMAN. You have two issues: one is the conflict of the provider-doctor. In a fee-for-service arrangement, a doctor may provide more reimbursements and more income. Here, if the patient is capitated, the doctor may decide to underserve and not make the referrals that come out of his pocket to pay for it. That is the conflict of interest.

The other is the financial stability of a institution that may not be able to meet the needs of a patient.

Have you found circumstances where a doctor, or several doctors working with Humana, have been financially limited to provide the care and pay for the care that is going to be needed?

Mr. STROPKO. There was a significant problem with IMC-affiliated providers. We have not really looked at the financial stability of the existing Humana Medical Plan network.

That was a very big problem with IMC, however. A substantial portion of IMC's affiliated providers were found to be very close to insolvent.

Mr. WAXMAN. The bigger problem you see then in this investigation is the conflict of interest influencing the physician not to provide the care the patients need. Correct?

Mr. STROPKO. We think it needs to be looked at closely in terms of risk-sharing arrangements for smaller entities.

Mr. WAXMAN. Some say we should repeal the statutory requirement that HMO's limit their Medicaid enrollment to not more than 50 percent.

Does GAO have a position on this?

Mr. STROPKO. We have always felt the 50 percent requirement was a major safeguard. Some of the more prominent problems HCPA has had with HMO's in the past usually involved a 50/50

issue, where the HMO's were right up against their ceiling or slightly over.

I think it is a very important safeguard. I think that has been our position.

Mr. WAXMAN. The problem is if they start taking too many government-insured patients, they start slipping in their quality of care. Is that what you see is at stake?

Mr. STROPKO. I think a large nongovernment-affiliated enrollment is an illustration that an HMO is able to succeed in the competitive marketplace. Employer groups, of course, have a little bit more leverage to withdraw from HMO's they are not satisfied with—a lot easier than Medicare can withdraw.

If you cannot succeed in the private market, I don't think you should be allowed to serve Medicare patients under a capitated arrangement.

Mr. WAXMAN. You see the 50/50 rule as a backup in case HCFA is not doing the monitoring. If there is a 50/50 arrangement, if they have the nongovernmental-insured patients, they are likely to want to hold on to that patient population and not offer the poor performances that we would hope HCFA would stop, but the marketplace would stop them.

Mr. WAXMAN. Thank you very much.

Our next witness is Dr. Gail Wilensky, Administrator of HCFA. She has been a forceful advocate and has encouraged beneficiaries to enroll in other limited access plans.

We appreciate your willingness to testify.

Your prepared statement will be in the record in full.

We would like to ask you to proceed and to stay around 5 minutes in your presentation.

STATEMENT OF GAIL R. WILENSKY, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. WILENSKY. Mr. Chairman, I am happy to be here today to discuss Medicaid coordinated care programs, primarily HMO's serving beneficiaries under risk contracts.

Health maintenance organizations with risk contracts comprise the largest portion of coordinated care under Medicare. There are 1.35 million beneficiaries enrolled with plans.

HMO's are valuable to Medicare beneficiaries. They reduce out-of-pocket costs and reduce paperwork, and provide more benefits than covered by Medicare.

The elderly are better served because care is coordinated. Patients are guided through a confusing "maze" of services, excessive and duplicative services are avoided, and complex needs are met. By managing care across the continuum of services, quality is improved; Medicare achieves better value for the taxpayer dollars we spend; and beneficiaries receive better value for their premiums and other out-of-pocket expenses.

HMO's have strong incentives to provide accessible, high quality, patient-oriented care and avert, to the extent possible, more serious illness. At the same time, coordinated care encourages cost-conscious decisionmaking that restrains unfettered spending.

Cost control that results in poor performance will lead to dissatisfied consumers and disenrollment from the plan. This balance in incentives focuses HMO's' attention on the efficient delivery of quality services to maintain a competitive edge.

The administration sees coordinated care as a priority that is key to improving the value of care that Medicare beneficiaries receive. We recognize the importance of strong Federal oversight of HMO operations in protecting the elderly enrolled in HMO's. Since HMO's first established a relationship with the Federal Government, a process has been in place to evaluate whether they meet basic standards for operations and the delivery of services. These standards were carried over to the Medicare program as a requirement for HMO's to contract on a risk basis.

HMO's seeking a risk contract must first complete an extensive application detailing their operations and delivery systems. During a site visit, HCFA reviews nine major areas of HMO operations to determine if the HMO is qualified to enter into a Medicare contract.

HMO's must meet specific requirements for: Organization and administration, fiscal soundness, incentive arrangements and utilization control, availability and accessibility of health services, quality assurance and peer review, marketing strategies, enrollment and disenrollment policies, claims processing and reporting, and appeals and grievances.

If the site review findings to support Federal qualification, HMO's are then eligible to contract with Medicare to serve beneficiaries.

Competitive medical plans, a coordinated care option that also contracts on a risk basis, must meet similar requirements to ensure their ability to serve Medicare beneficiaries.

At least every 2 years, we conduct a comprehensive monitoring review of contract performance. More frequent reviews may be triggered by complaints or to follow up on problems identified in monitoring reviews.

During a monitoring site visit, a Federal team of central and regional office personnel reviews the major areas of operations. When a problem or deficiency is identified, a plan of correction must be submitted and compliance achieved at the earliest possible date. Failure to do so can result in termination of the Medicare contract.

Last March I approved the reorganization of Medicare-coordinated care activities. I established a new Office for Prepaid Health Care Operations and Oversight within the HCFA organizational component responsible for the day-to-day operations of the Medicare program.

The operations component is responsible for monitoring provider compliance with Federal standards, ensuring that quality assurance functions are effective, and making sure bills are paid and data flows. The operations staff works closely with the regional offices which oversee operations in the field.

Placing managed care activities in the operations block will improve coordination and communication and facilitate quicker action to address problems as they arise.

Shortly after the reorganization, this new office undertook a comprehensive effort to strengthen its operational and oversight responsibilities. To ensure more uniform application of Federal requirements we are preparing guidelines in manual form. The manual will be largely completed by December.

We are also developing a streamlined enforcement process to achieve changes in HMO performance. We will be able to target enforcement actions to specific kinds of problems, establish criteria for their use, and set appropriate time frames for taking such actions. We have offered to share these guidelines with the GAO, and would appreciate their input. We expect to have this revised enforcement process developed by January 1992.

As part of our efforts to improve the existing monitoring and enforcement processes, we will be looking to strengthen the role of our regional offices. We see our regional offices as a valuable resource in overseeing Medicare managed care activities.

With the standardization of our policies and procedures, regional staff will monitor more easily and closely ongoing HMO operations.

We expect to publish a final regulation by early next year. Intermediate sanctions and civil monetary penalties will be an important tool to effect compliance with Federal requirements.

We will continue to use administrative procedures to secure the cooperation of HMO's that do not resolve problems in a timely manner. For example, in at least two instances we have forced compliance by suspending action on requests for expansion of current contracts or the addition of new contracts.

We expect to publish a proposed rule early next year and to solicit public comment, which we consider an essential step given the complexity of the issues and the broad impact of this rule on the HMO industry.

Our strengthened operations and monitoring activities will facilitate proper oversight as we move into a broader range of managed care activities.

The administration has submitted several proposals in its fiscal year 1991 budget to strengthen risk contracting.

These include establishing an outlier pool for risk contractors to pay for a portion of high cost cases; establishing a new risk contracting option to allow plans to market services exclusively to retirees in employer groups; providing rebates on a portion of Medicare part B premiums to beneficiaries enrolled in Medicare risk plans that charge premiums; modifying the Health Care Payment Plan option. Both beneficiaries and the Medicare program are vulnerable under the HCPP option.

Finally, we have now designated 15 States to initiate a Medicare SELECT program by July 30, 1992. Medicare SELECT is a new coordinated care option where beneficiaries purchase Medigap coverage for care received within a managed care network defined by the Medicare SELECT insurer.

Full Medicare coverage plus Medicare's deductibles and coinsurance are provided if the beneficiary stays within the network. If the beneficiary goes outside the managed care network, full coverage is provided, but the Medigap insurer may not pay for Medicare's deductibles and coinsurance.

Coordinated care provides a preferred continuum of quality health care at an affordable price to the Medicare program and its beneficiaries.

I believe the most important reason for managed care is enhanced quality and accountability. That is why HCFA has put so much time and effort into ensuring the sound administration of this priority program while holding participant contractors responsible for the services they provide.

It is my obligation, as HCFA Administrator, to promote viable options to health care that are reliable and affordable.

I will continue to support the development of coordinated care programs wherever and whenever circumstances prove beneficial to the Medicare program and the beneficiaries we serve.

I will be glad to answer any questions you may have.

[Testimony resumes on p. 39.]

[The prepared statement of Ms. Wilensky follows:]

STATEMENT OF

GAIL R. WILENSKY, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Good morning Mr. Chairman and Members of the Committee. I am happy to be here today to discuss Medicare coordinated care programs, primarily HMOs which serve Medicare beneficiaries under risk contracts.

INTRODUCTION

Medicare Health Maintenance Organization (HMO) risk contracts are the largest portion of coordinated care activities under Medicare. There are 1.35 million beneficiaries enrolled in HMOs and Competitive Medical Plans (CMPs) under risk contracts with Medicare.

HMOs are valuable to Medicare beneficiaries. They generally reduce out-of-pocket costs and involve less paperwork. HMOs provide more services to beneficiaries than traditionally covered by Medicare. For example:

- 87 percent of HMOs offer routine physicals;
- 85 percent offer eye examinations;
- 77 percent offer immunizations;
- 65 percent offer ear examinations; and
- 44 percent offer health education programs.

Beneficiaries also are better served because care is coordinated. Patients are guided through an often confusing "maze" of services, excessive and duplicative services are avoided, and complex needs are met. By managing care across a continuum of services, quality is improved; Medicare achieves better value for

the taxpayer dollars we spend; and beneficiaries receive better value for their premiums and other out-of-pocket expenses.

We are only beginning to realize the real potential for coordinated care to improve the quality of services provided to Medicare beneficiaries. For example, a number of our HMOs provide services specifically targeted towards the special needs of the elderly. Many Medicare HMOs use gerontologists and other practitioners who specialize in treating senior citizens. Some HMOs accomodate Medicare beneficiaries by providing care in centers equipped with amenities to meet their needs. Other plans are encouraging seniors to meet with pharmacists to evaluate whether their medications are appropriate and to avoid potentially harmful drug interactions.

HMOs have strong incentives to provide accessible, high quality patient-oriented care and avert, to the extent possible, more serious illness. At the same time, coordinated care encourages cost conscious decision making that restrains unfettered spending.

Coordinated care offers the potential for cost control, an essential element in considering more fundamental reforms in health care delivery and financing. Yet, cost control that results in poor performance will lead to dissatisfied consumers and disenrollment from the plan. This balance in incentives

focuses HMOs' attention on the efficient delivery of quality services to maintain a competitive edge.

FEDERAL OVERSIGHT

The Administration has made coordinated care a priority that is key to improving the value of care that Medicare beneficiaries receive. Because of this, we recognize the importance of strong Federal oversight of HMO operations and our responsibility to protect Medicare beneficiaries enrolled in HMOs. Since HMOs first established a relationship with the Federal government, a process has been in place to evaluate whether they meet basic standards for operations and the delivery of services. These standards were carried over to the Medicare program as a requirement for HMOs to contract on a risk basis.

HMOs seeking a risk contract must first become federally qualified. They must complete an extensive application which details specifics of their operations and delivery systems. During a site visit, HCFA reviews nine major areas of HMO operations to determine if the HMO is qualified to enter into a Medicare contract. Specifically, HMOs must meet requirements for:

- Organization and Administration - The HMO must have administrative and managerial arrangements to effectively organize and guide the operations of the

HMO and to fulfill the requirements of the Medicare contract.

- Fiscal Soundness - Each federally qualified HMO must have a fiscally sound operation and submit periodic financial reports.

- Incentive arrangements and utilization control - The HMO must assume full financial risk on a prospective basis for the provision of health care services to enrollees, and should have effective procedures to monitor utilization and to control the cost of services.

- Availability and Accessibility of Health Services - The HMO must provide all required Medicare Part A and B benefits and supplemental services offered to enrollees through Medicare approved providers; must ensure that providers are geographically available and accessible; and, must provide health services in a manner which assure continuity of care.

- Quality Assurance and Peer Review - The HMO must have an internal plan to ensure the quality of care provided, as well as an external PRO review of HMO services.

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- Marketing - The HMO must provide adequate written descriptions of rules, procedures, benefits, fees and other charges, services and information so that beneficiaries can make informed decisions about enrollment. The HMO cannot distribute any brochures, application forms, or other promotional material without HCFA review and approval. In addition, the HMO must ensure its employees do not conduct prohibited marketing activities.

- Enrollment and Disenrollment - An HMO must enroll all eligible individuals on a first-come, first-served basis to the limit of its capacity, and must notify beneficiaries in writing of the acceptance or denial of the application. An enrollee may disenroll at any time by giving the HMO a signed, dated request in the form and manner prescribed by the HMO.

- Claims Processing and Reporting - The HMO is financially responsible for the health care services provided to its enrollees; assumes financial responsibility for emergency needed services obtained outside the HMO; and, must provide prompt payment of claims. All HMOs are required to provide audited financial statements on an annual basis. Most HMOs routinely provide quarterly financial reports.

- Appeals and Grievances - The HMO is responsible for establishing and maintaining the HCFA appeal procedures for all initial determinations and must have internal procedures to handle all complaints.

The results of the site review findings are evaluated to determine the capability of the HMO to serve Medicare beneficiaries. Federal qualification is then either approved or denied. Once federally qualified, HMOs are eligible to contract with Medicare to serve beneficiaries.

Competitive Medical Plans, a coordinated care option that also contracts on a risk basis, must meet similar requirements to ensure their ability to serve Medicare beneficiaries.

At least every 2 years, we conduct a comprehensive monitoring review of HMO and CMP contract performance. More frequent reviews may be triggered by complaints or to follow up problems identified in monitoring reviews.

During a monitoring site visit, a federal team of central and regional office personnel thoroughly reviews the major areas of HMO and CMP operations. When a problem or deficiency is identified, HMOs and CMPs must submit a plan of correction and come into compliance at the earliest possible date. Failure to do so can ultimately result in termination of the Medicare

contract.

REORGANIZATION AND STRENGTHENING THE OVERSIGHT PROCESS

As the Administration further expands coordinated care, we are improving our ability to ensure accountability for managed care activities.

Last March, Secretary Sullivan concurred with my plans to reorganize the management and operations of Medicare managed care activities. This reorganization aligns the oversight of coordinated care activities with the mainstream Medicare program.

I established a new Office for Prepaid Health Care Operations and Oversight within the HCFA organizational component responsible for the day-to-day operations of the Medicare program.

The Operations component is responsible for monitoring provider compliance with federal standards, ensuring that quality assurance functions are effective, and making sure bills are paid and data flows. The Operations staff provides experienced and competent oversight of all Medicare line operations. They work closely with the regional offices which oversee operations in the field. Placing managed care activities in the Operations block will improve coordination and communication and facilitate quicker action to address problems as they arise.

Quality Improvement Initiative

Shortly after the reorganization, this new office undertook a comprehensive effort to strengthen its operational and oversight responsibilities. In order to ensure more uniform application of federal requirements and standards, we are preparing guidelines in manual form and expect to have major portions of the manual completed by December.

We are refining our current monitoring and enforcement processes to be better able to identify and correct problems in HMO performance. We are working to improve use of existing data sources to target our monitoring efforts. For example, we believe our current monitoring process can be improved through better use of information on beneficiary complaints, beneficiary requests for reconsideration of an HMO's decision not to provide or pay for certain services, and PRO review information.

We are also developing a strengthened and streamlined enforcement process to more effectively use available sanctions to achieve changes in HMO performance. We will be developing a process that will target specific enforcement actions to specific kinds of problems, establish criteria for their use, and set appropriate time frames for taking such actions. We have offered to share these guidelines with the GAO, and would appreciate their input. We expect to have this revised enforcement process developed by January 1992.

As part of our efforts to improve the existing monitoring and enforcement processes, we will be looking to strengthen the role of our regional offices. We see our regional offices as a valuable resource in overseeing Medicare managed care activities. With the standardization of our policies and procedures, regional staff will monitor more easily and closely ongoing HMO operations.

Intermediate Sanctions

On July 22, we published a proposed rule to implement the intermediate sanction and civil monetary penalty authority which defines eight violations under which sanctions may be imposed. These violations include: failure to provide a beneficiary with medically necessary services; abuses of marketing, enrollment, reporting or claims payment; and, contracting with an entity excluded from Medicare participation.

We expect to publish a final regulation by early next year. We believe that intermediate sanctions and civil monetary penalties will be an important tool to effect compliance with federal requirements.

I would point out that we will continue to use administrative procedures to secure the cooperation of HMOs that do not resolve problems in a timely manner. For example, in at least two instances we have forced compliance by suspending the processing

of requests for expansion of current contracts or the addition of new contracts.

Physician Incentive Regulation

We are also working on the physician incentive regulation as a high priority. OBRA 90 requires regulations to define physician incentive arrangements that place physicians at substantial risk for services they do not provide. If such risk is imposed on individual physicians or groups, the HMO will be required to have adequate stop-loss protection and to conduct member satisfaction surveys to determine if there are problems with access to health care.

We expect to publish a proposed rule early next year and to solicit public comment, which we consider an essential step given the complexity of the issues and the broad impact of this rule on the HMO industry.

FUTURE PLANS

Our strengthened operations and monitoring activities will facilitate proper oversight as we move into a broader range of managed care activities.

Fiscal Year 1992 Proposals

The Administration has submitted several proposals in its fiscal year 1992 budget to strengthen risk contracting.

We are proposing to establish an **outlier pool** for risk contractors to pay for a portion of high cost cases. The outlier pool would help stabilize payments to HMOs that experience substantial loss on their Medicare business. It would improve the accuracy of HMO payments and could be readily implemented.

Our FY 1992 budget also proposes **establishing a new risk contracting option** to allow plans to market services exclusively to retirees in employer groups. Currently, plans must be open to all beneficiaries in a service area and provide a uniform benefit package. This proposal would remove the requirements that present barriers to employer contracting, and could spur a substantial growth in enrollment as employers turn to HMOs as a cost-effective answer to escalating retiree health benefit costs.

We also propose **providing rebates on a portion of Medicare Part B premiums** to beneficiaries enrolled in Medicare risk plans that charge premiums. This would further encourage enrollment.

We would also like to modify **the Health Care Prepayment Plan** (HCPP) option. Both beneficiaries and the Medicare program are vulnerable under the HCPP option. HCPPs can conduct health screening prior to enrollment. In addition, they do not have to meet other Medicare provisions intended to protect beneficiaries, including those relating to quality assurance systems, access to care, appeal rights, premium regulation, and insolvency

protection. Further, HCPPS are paid on a cost basis which provides no incentive to control spending.

We believe that organizations that qualify for an HMO or CMP contract should be precluded from entering an HCPP agreement. Other organizations eligible for the HCPP option should be required to have beneficiary protections in place.

To expand coordinated care, we are proposing to create a point-of-service (POS) option. Under this option, beneficiaries would not have to enroll in a plan, but would choose, on a service-by-service basis, whether to receive care through a coordinated care system. New contracting entities would be established with the responsibility to develop a comprehensive network of preferred providers. Preferred providers would be selected based on quality assurance systems and practice patterns. The POS contractor would have discretion to establish alternative payment arrangements thorough negotiated discounts and competitive bidding.

A POS contractor could negotiate a reduced, bundled price for Part A and B services associated with high cost and high volume surgical procedures. Bundling services into a negotiated global fee should not only reduce total spending, but also improve quality by having physicians and hospitals work together under the same payment incentives to care for the patient.

Medicare SELECT

Finally, we have designated fifteen States to initiate a Medicare SELECT program by July 30, 1992. Medicare SELECT is a new coordinated care option where beneficiaries purchase medigap coverage for care received within a managed care network defined by the Medicare SELECT insurer. Full Medicare coverage plus Medicare's deductibles and coinsurance are provided if the beneficiary stays within this network. If the beneficiary goes outside the managed care network, full coverage is provided, but the Medigap insurer may not pay for Medicare's deductibles and coinsurance.

CONCLUSION

Coordinated care provides a preferred continuum of quality health care at an affordable cost to the Medicare program and its beneficiaries.

I believe the most important reason for managed care is enhanced quality and accountability. That's why HCFA has put so much time and effort into ensuring the sound administration of this priority program while holding participant contractors responsible for the services they provide.

It is my obligation, as HCFA Administrator, to provide viable options to health care that are as reliable and affordable as those offered by coordinated care programs. I will continue to encourage and support the development of these programs wherever and whenever circumstances prove beneficial to the Medicare program and the beneficiaries we serve.

Mr. WAXMAN. Thank you, your testimony presents to us a picture of why there is a desirability of coordinated care arrangements and also the effectiveness of policies and procedures that you have in place to assure that these organizations meet the requirements of the law.

I don't know if you are familiar with the GAO report, but they say that in their words there is an unwillingness and inability to enforce Medicare requirements on HMO's serving Medicare beneficiaries.

How is it, in your opinion, that these problems occurred in the Humana plan, and why after 3 years of documenting the violations of that plan, has HCFA been unable to achieve full compliance with the Medicare requirements?

Ms. WILENSKY. I think the issues in the GAO report were recognized by HCFA. The GAO recognized that we recognized them. We are moving to have the changes occur to take care of the problems.

It was a reason why I encouraged the reorganization of HCFA oversight and monitoring last spring.

I think having HMO oversight done by the people who actually are involved in the operations and the day-to-day work in the regions is a very important change from what had occurred. We gave oversight responsibility to people who are experts in operations, and left the policy part of the HMO activities with the policy people, rather than having them do it.

I think that we have intentions to have in place, as of January, strategies that will respond to the issues that were raised.

You indicated, correctly, that I am a major proponent of coordinated care plans of all sorts, including the HMO. I recognize that makes it particularly important that I make sure that this preferred strategy receives good oversight. That is why we are moving in that direction.

Mr. WAXMAN. I share your support for HMO's and related kinds of plans. That is why I am concerned when we get the reports of scandals.

If this were the first one, I would say, well, we have to do something about it, we didn't know something like this would happen. This is not the first problem, however. This is the second, third, fourth or fifth.

In my years in the California legislature, we had scandals in the late 1960's and 1970's, over prepaid plans that were abusing their marketing and abusing the patients by not providing care for them.

Could you explain why HCFA took over 3½ years to publish a proposed rule to implement the intermediate sanction and civil and monetary penalties that were authorized by OBRA 1987?

Ms. WILENSKY. My understanding is that changes kept occurring in the legislative authority—in this case, two different acts in 1988 and 1989 made changes in this area.

One of the problems was that these changes made it difficult for us to issue regulations. The proposed rule that we issued in July, which we believe was critical in order to actually impose the intermediate sanctions, kept getting delayed.

There was some twist that would happen with each new piece of legislation. That is at least what I am told.

Again, let me make clear, I am a very active advocate of intermediate sanctions.

Mr. WAXMAN. I gather the changes in legislation were not changes in the requirements but were additions.

Ms. WILENSKY. They are changes that require us to go back through the rulemaking process, to the people who write the rules and to go through the clearance process.

I appreciate that what may seem to be a smaller or minor change to the legislative branch can cause us executive branch people to make major revisions because of the APA review and the process.

Mr. WAXMAN. Do your rules involve complex procedures for determining the timing for enforcement actions or would you describe them as restatements of the statutory provisions that would require further policy guidance to enforce?

Ms. WILENSKY. The latter.

Mr. WAXMAN. Well, I can't imagine if changes in congressional details on this mean you could not come up with a restatement of statutory provisions in a 3½ year period.

Do you believe in the risk arrangements for physicians in the Humana plan, and can you share with us some of your thinking about how to implement the limits on physician risk in OBRA 1990?

Ms. WILENSKY. Well, this is an area that the Congress itself, I know, found rather difficult. It is my understanding that the Congress had initially attempted to define incentive arrangements with greater specificity than they ended up with.

What concerned Congress were prohibitions that it might want to put in place in terms of incentive arrangements for physicians, and after a several year period, because of the difficulty and complexity of the issues, did not do as much definition as it originally had intended to.

We are working on this regulation.

A couple of things about it: the first is we hope to have it out early in 1992; the second is that it will prohibit direct ties between a specific service that a physician does and any incentive that is directly tied to that specific service, that there will be some relationships between what is done in the hospital and the physician's risk, and that there will be limits placed on what that staff relationship will be.

Mr. WAXMAN. Let's go back to the fact that your regulations or proposed rulings will be pretty much restatements of the statutory provisions. Will that be enough guidance for your district offices that told the GAO that they did not feel that they had enough guidance to take actions?

After all, they could have read the statute.

Ms. WILENSKY. My understanding is that the opinion that we had was that until the regulations were in force, we would not be able to sustain a court challenge if the sanctions were imposed. If there is a need, manual instructions will also be issued.

I am told that is, in fact, what we are intending to do. There will be a manual for regional offices. But the real reason for not using them until the regulation was out is that they would not be upheld in court.

Mr. WAXMAN. Could you tell us how many administrative enforcement actions you have taken against Medicare risk contractors since 1987, and what mechanisms HCFA has in place for monitoring compliance beyond site visits every 2 years?

Ms. WILENSKY. Okay. There are several.

Mr. WAXMAN. Let's go over the first. How many administrative enforcement actions have you taken against Medicare and Medicare risk contractors since 1987?

Ms. WILENSKY. We have terminated three contractors: IMC, Findlay and Island Care.

Mr. WAXMAN. Were they adverse determinations or people who volunteered to withdraw?

Ms. WILENSKY. No, those were adverse. We have had 80 for-cause investigation visits, and we have had some technical assistance visits as well.

Mr. WAXMAN. What do you have for monitoring beyond site visits every 2 years?

Ms. WILENSKY. There are several activities. As I think you know, we are in the process of changing the PRO review strategy that we have had in place. In addition to the 2-year reviews, we have for-cause investigations, investigations by the PRO, and beneficiary complaints will also spur an investigation.

In the new PRO strategy which we hope to have in place early in 1992, we will be changing a number of things, including how we go about sampling. But we will also be reviewing a percentage of all deaths that occur in the HMO.

They will be subject to review as part of the new PRO review strategy, plus we will do an investigation of all complaints and review a sample of all other cases to see whether or not there is a problem.

There are two enforcement mechanisms in place. One has to do with the site visit, making sure that the processes, themselves, are in place: Quality assurance, financial soundness, et cetera.

The other is the PRO review, looking at case records which in many ways is the most direct review of quality. The site visits determine whether the quality assurance process and financial structure meet Federal standards. The PRO is the direct quality mechanism for seeing whether care is adequate.

Mr. WAXMAN. Do you get beneficiary compliance?

Do they know they can call a certain number to complain and make known their concerns?

Ms. WILENSKY. Yes. That is the equivalent of a condition of participation in the Medicare contract, to have a way that beneficiaries can complain.

Mr. WAXMAN. Complain to you or the HMO?

Ms. WILENSKY. Complain to the HMO, to have a regular process for hearing grievances. They can, obviously, directly complain to Medicare as well. That is something that is not inappropriate. But having a regular structure in place so that beneficiary concerns and complaints can be brought to the HMO, can be acted upon, is one of the requirements for being a Medicare HMO contractor.

Mr. WAXMAN. It is certainly worthwhile having a way for patients to call the HMO to tell them they are unhappy, but if the HMO is not doing its job because they don't want to spend money

on these people, hearing a complaint may not be all that influential to them, because they are doing what they are doing for greed.

Ms. WILENSKY. We monitor as to how the HMO's go about taking care of the process they use for a grievance or appeal. Ultimately, the Medicare beneficiary can vote with his or her feet as their own ultimate solution to a problem, and they can raise a complaint to the Medicare program, all of which——

Mr. WAXMAN. Or they can call their Congressman.

Ms. WILENSKY. We usually know when that occurs. HMO's have a much more elaborate structural process than is available to a Medicare beneficiary through the fee-for-service system. This process is more extensive than what normally exists, particularly for the ambulatory care portion of Medicare.

Mr. WAXMAN. In Florida the GAO found no appeals process. Do you expect that will be now corrected?

Ms. WILENSKY. Yes.

Mr. WAXMAN. When I had Ms. Shikles here I asked her about the issue of the 50/50 rule. They argue it is a good idea to have that rule in place as a safeguard, because government regulation is not always so effective in getting regulatory groups to do their jobs. You indicated people can walk out and disenroll and go to another health care provider. That is for Medicare beneficiaries.

Do you think that 50/50 rule is a safeguard, not because it just involves Medicare beneficiaries, but private pay patients as well?

Ms. WILENSKY. I think it is obviously a proxy. I frankly would prefer to have better direct quality assurance measures and not rely on those kinds of proxies.

It is not clear to me that it is a particularly good proxy. I would like to have better direct quality assurance measures that we all could agree with, you and your committee, and not use artificial proxies.

I think that, contrary to what is sometimes cited as the private sector keeping Medicare honest, actually the private sector enrollee is under far greater constraint than the Medicare enrollees. My insurance with the government lets you change once a year unless there is direct, for-cause reasons for disenrollment. Medicare beneficiaries can walk in 30 days.

I think it is the other way around. The Medicare population may be what is keeping the HMO honest for the private sector. They certainly have far more at risk in terms of disenrollment. I personally——

Mr. WAXMAN. You think the 50/50 rule is a good protection for the private sector?

Ms. WILENSKY. If we could find ones that we agree with.

I would rather have better direct quality assurance measures. I am not particularly keen on what is obviously a proxy. I assume you would agree. If we could find ones that we agree were good direct measures, I prefer those.

Mr. WAXMAN. I am concerned that if we are not going to have proxies, we have to have pretty strong government regulatory enforcement that has not always been up to performance. Or even the realistic ability to do the job that has to be done, since there are people who would like to take advantage of the situation. Per-

haps that is human nature, to take advantage of the situation for their own financial enhancement.

I, too, share with you the goals in trying to make this HMO program for Medicare beneficiaries work. We stand ready to be helpful. We don't want to pass laws that will set you further behind in your efforts to enforce the ones that are on the books, but we will want to continue our oversight responsibilities to give you new tools, if necessary.

Ms. WILENSKY. I think that the rules on the books are rules that will provide important quality assurance. I think it is important for us to enforce them vigorously. I think that the organizational change that we made ought to have that happen.

We have a lot of changes that will begin in January 1992. I wish it could have taken less time, but when you make bureaucratic reorganization to improve what wasn't working well, accomplishing it in a 9-month period is not too bad.

Mr. WAXMAN. Since we have you here, I will ask if you would come into the back room and have a conversation, and we will recess this hearing and reconvene as soon as we have completed our talk. So we stand recessed.

[Brief recess.]

Mr. WAXMAN. Our next panel of witnesses is composed of representatives of organizations that provide advocacy and beneficiary assistance to seniors. Aileen Harper is assistant director of the Medicare Advocacy Project in Los Angeles, Calif. MAP is an independent, nonprofit organization providing free educational counseling and legal services to Medicare beneficiaries in Los Angeles. MAP has provided help to many of my constituents, and I am especially pleased Ms. Harper could be with us today. Sylvia Torgan is president and founder of the HMO Patient Advocate Committee of Broward County, Fla. The committee provides assistance to Medicare beneficiaries in filing complaints concerning HMO's. Perry Amsden is a member of the National Legislative Council of the American Association of Retired Persons from Brewer, Maine.

I want to welcome all of you to our subcommittee and thank you for being here today. Your prepared statements will be in the record in full. We would like to ask you to limit your oral presentation to no more than 5 minutes.

STATEMENTS OF AILEEN HARPER, ASSISTANT DIRECTOR, MEDICARE ADVOCACY PROJECT; SYLVIA TORGAN, PRESIDENT, HMO PATIENT ADVOCATE COMMITTEE; AND PERRY AMSDEN, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. HARPER. Thank you, Mr. Chairman, for inviting us to attend these oversight hearings. I am Aileen Harper, Assistant Director of the Medicare Advocacy Project. The Medicare Advocacy Project, also know as MAP, is an independent nonprofit advocacy organization that provides free educational, counseling, and legal services to Medicare beneficiaries in Los Angeles County. We assist more that 5,000 individual clients and educate more than 10,000 persons annually.

Over the last 7 years, MAP has gained substantial experience with Medicare risk-contract HMO's in Los Angeles County. HMO-related problems constitute 40 percent of the more than 700 legal cases we handle annually, an astonishing and disturbing figure.

Through a grant from the Alliance Health Care Foundation, MAP is currently conducting a study of Medicare risk-contract HMO's in California.

I am here today to speak to you about the HMO problems and concerns expressed by Medicare beneficiaries in MAP's service area. These are pervasive problems, not isolated incidents, revealing serious systemic problems in the areas of HMO marketing, quality of care, and the appeals process.

Over the last several years MAP has witnessed a pattern of inadequate monitoring and poor enforcement of HMO Medicare activities. This testimony is not meant to indict the HMO industry or the positive effects of HMO enrollment for Medicare beneficiaries. To the contrary, MAP believes that there are many advantages for Medicare beneficiaries who join HMO's, including tremendous cost savings on medical care.

In addition, we recognize that HMO's and other forms of managed care must seriously be considered by government and consumers as helpful models that may effectively control health care costs and provide quality care.

Over the last 5 years, Los Angeles County has experienced massive Medicare HMO penetration. There are currently 420,000 Southern California Medicare beneficiaries enrolled in risk-contract HMO's. Because of this market penetration, Medicare risk-contract HMO's aggressively compete with each other to enroll Medicare beneficiaries.

Unfortunately, the high level of HMO marketing activity has contributed to the use of improper marketing practices by some HMO's. These include forging beneficiary signatures, enrolling beneficiaries who are mentally confused, and using undue pressure to persuade beneficiaries to enroll. Medicare beneficiaries are harmed by improper marketing practices.

The case of Agnes B is a good example. An HMO marketing agent persuaded her to sign an enrollment form, telling her that it would only document his visit. Mrs. B had a fifth grade education and relied on his honesty. She learned of her HMO enrollment when Medicare claims were denied on non-HMO services. She now faces collection action for medical bills she is unable to pay.

HCFA has not been rigorous in its enforcement of Medicare HMO regulations designed to protect beneficiaries from marketing abuse. Consumer complaints about marketing are responded to in an ad hoc manner, and are not recorded in a way that provides HCFA with data to evaluate HMO compliance.

HCFA monitoring has been ineffective in ensuring HMO compliance with marketing regulations. Although serious marketing problems have been recorded and documented, they continue to occur. We recognize that HCFA has developed and used retroactive disenrollment to remedy the adverse consequences of improper HMO marketing. This process has been a safety net for many. Nevertheless, it does not correct systemic HMO marketing problems.

HCFA should assume the regulatory authority to impose intermediate sanctions, such as monetary penalties and suspension of enrollment payments, when HMO practices violate the law. With that authority, we hope that HCFA will significantly improve enforcement in HMO compliance.

Our recommendations for rulemaking and legislation in the area of marketing include the prohibition of HMO's marketing in the home.

Quality care is another area in which we see substantial problems. There are currently financial incentives in the HMO system to underserve. This is especially true for contracting physicians and medical groups who are placed at financial risk when they authorize care for their patients.

Denials or delays in obtaining HMO referrals for specialty services and elective surgery are common. In some instances the HMO physician or medical group inappropriately denies a referral for needed care. In others, a referral is made, but patients experience long delays in getting appointments.

An example of the harm from HMO denials is Mr. M, an elderly stroke victim whose health seriously deteriorated over months when his HMO physicians failed to provide needed tests and physical therapy. Now he is partially paralyzed, has difficulty speaking, and can only walk with assistance.

There is a pattern of HMO denial of hospital admissions, skilled nursing facility care, and home health care coverage. HMO's frequently deny access to these needed services. Beneficiary complaints are substantiated by nursing facility and home health care providers, who report that Medicare enrollees are often denied needed care.

Three key factors contribute to the occurrence of HMO quality of care problems. First, HMO's fail to adequately oversee their contractor physicians. Second, the transfer of financial risk to HMO contractor providers for the provision of some services influences decisions about patient care. Third, PRO's do not have the information or authority to adequately oversee HMO quality care.

Beneficiaries have limited options when faced with quality of care problems, because the Medicare HMO appeals process does not provide for expedited review of quality-of-care disputes. Beneficiaries often disenroll from the HMO to obtain needed care.

Our recommendations for improving HMO quality of care include placing restrictions on the level of financial risk HMO's can assign to contracting physicians and medical groups. Plagued by structural defects and HMO practices that undermine its limited effectiveness, the Medicare HMO appeals process does not protect beneficiary rights. Slow and cumbersome, the process is further weakened by conflict-of-interest factors.

Although HMO's have a clear financial interest in denying payment or coverage, the HMO's in their contract to providers are responsible for making initial coverage decisions.

HMO contractor providers frequently fail to make coverage or claim payment decisions in the time frame specified by law. In addition, HMO providers commonly do not provide enrollees with adequate notice of their appeal rights. Some HMO's routinely

ignore these violations of the appeals process and refuse to take any action to remedy the situation.

Last, HMO's abuse the appeals process when they arbitrarily deny payment of emergency and urgent care claims. In these cases, enrollees are unfairly forced to appeal claims. Beneficiaries who are unable to file an appeal due to age or illness must pay for services that should be covered.

In conclusion, serious HMO marketing quality-of-care and appeal process problems adversely affect Medicare HMO enrollees' access to quality care in the Southern California area. Without aggressive HCFA monitoring and enforcement, these systemic problems will continue unchecked, and beneficiaries will remain unprotected. I am prepared to answer questions.

Thank you.

[Testimony resumes on p. 77.]

[The prepared statement and attachments of Ms. Harper follow:]

TESTIMONY

of the

MEDICARE ADVOCACY PROJECT

Aileen Harper, M.S.P.H.
Assistant Director

Good morning, Mr. Chairman and members of the Committee. I am Aileen Harper, Assistant Director of the Medicare Advocacy Project. The Medicare Advocacy Project, also known as MAP, is an independent non-profit advocacy organization that provides free educational, counseling and legal services to Medicare beneficiaries in Los Angeles County. Our professional staff and volunteer counselors assist more than 5,000 individual clients and present educational programs to more than 10,000 persons annually.

In addition, through state and federal administrative and legislative advocacy, litigation and research, MAP works to improve health care delivery to the Medicare population in California and the United States.

Over the last seven years, MAP has gained substantial experience with Medicare risk contract HMOs in Los Angeles County. Almost every day Medicare beneficiaries contact MAP for information on HMOs and for assistance with HMO problems. HMO related problems constitute 40% of the more than 700 legal cases we handle annually, an astonishing and disturbing figure. In addition, MAP receives many requests from other advocacy organizations for advice and technical assistance regarding HMO problems. MAP's educational forums are in high demand by beneficiaries who seek objective consumer oriented information regarding Medicare HMO issues. Also, through a grant from the Alliance Healthcare Foundation, MAP currently is conducting a study of problems with Medicare risk contract HMOs in California.

I am here today to speak to you about the HMO problems and concerns expressed by Medicare beneficiaries in MAP's geographic area. These are pervasive problems, not isolated incidents, revealing serious systemic problems in the areas of HMO marketing,

quality of care and the appeals process.

MAP has found HCFA unwilling to recognize and address these systemic concerns. Over the last several years, MAP has witnessed a pattern of inadequate monitoring and poor enforcement of HMO Medicare activities by HCFA.

I want to stress at the outset that this testimony is not meant to indict the HMO industry or the positive aspects of HMO enrollment for Medicare beneficiaries. To the contrary, MAP believes that there are many advantages for Medicare beneficiaries who join HMOs, including tremendous cost savings on medical care.

Nevertheless, systemic marketing and quality problems and lack of an effective appeals process in the Medicare capitated HMO program must be corrected if we are to protect adequately all Medicare HMO enrollees.

MAP hopes that the testimony today will provide the Committee with insights into real-life issues regarding Medicare HMOs as well as some legislative and administrative remedies to improve the system.

HMO MARKETING PROBLEMS

Background

Over the last five years, Los Angeles County has experienced massive Medicare HMO penetration. Six HMOs enroll Medicare beneficiaries in southern California. There are currently 420,000 southern California Medicare beneficiaries enrolled in risk contract HMOs. Because of this market penetration, Medicare risk contract HMOs aggressively compete with each other to enroll Medicare beneficiaries.

As a result of this marketing effort, new HMO enrollment has increased dramatically. For example, from January 1, 1991 through the end of October 1991, Medicare HMO enrollment increased by 32,186 beneficiaries.

Use of Illegal and Improper HMO Marketing Practices

The high level of HMO marketing activity has drawn increasing numbers of beneficiaries into Medicare HMOs. Unfortunately, it also has contributed to the use of both questionable and illegal marketing practices by some HMOs. Our experience in the Los Angeles area indicates that incidents of improper marketing escalate when an HMO moves into a new area or when multiple HMOs are marketing in the same geographic region.[1]

Some HMOs in southern California have engaged in the following practices: forging beneficiaries' signatures; telling benefici- aries that by signing an enrollment form they were only documenting the HMO representative's visit; enrolling beneficiaries who are mentally confused; and using undue pressure to persuade beneficiaries to enroll. Attachment 1 describes a number of cases which illustrate HMO marketing and quality of care problems. The case of Blanche C. illustrates such abuse:

Blanche C.

Blanche C. is a 71 year old Medicare beneficiary. In May of 1991, responding to a request for additional information on the Family Health Plan ("FHP") Senior Plan, an FHP marketing agent visited her home. After listening to his presentation, Ms. C. told the representative that she was not interested in enrolling. She later threw away the information the marketing representative had left behind.

[1] Improper marketing is not an industry-wide phenomenon. Of the risk contract HMOs actively marketing in southern California, MAP is aware of only two that have engaged in significant marketing abuses.

Much to her surprise, Ms. C. learned she was enrolled in FHP when Medicare began denying her claims due to HMO enrollment. Ms. C. contacted MAP to investigate her FHP enrollment. MAP filed an inquiry with FHP and forwarded a copy of Ms. C.'s enrollment records to her. Ms. C. contends that the signature on the form was not hers and was forged.

On her behalf, MAP filed a marketing complaint. Following an investigation, FHP determined that there was no evidence of fraudulent enrollment but, nevertheless, agreed to pay any Medicare denied claims for the period of Ms. C.'s enrollment in FHP. The signature on the enrollment form appears quite different from Ms. C.'s signature.

Beneficiaries have also reported questionable marketing practices which have been approved or permitted by HCFA. These include the use of advertisements and direct mail literature which do not clearly identify the HMO. For example, one HMO recently sent out a direct mail piece from "M/C Research" which appeared to be a consumer survey, totally unrelated to any HMO or medical provider (Attachment II). The questionnaire not only failed to identify the HMO, but asked questions which would permit the HMO to market to younger, healthier Medicare beneficiaries. MAP learned that consumers who responded were contacted by the HMO to schedule an in-home marketing visit. Yet HCFA Region IX advised MAP that it had approved the survey as a marketing tool.

Probably the most significant HMO marketing problem MAP encounters concerns the enrollment of persons who, due to age, disability or education, did not understand HMO membership rules, in particular the lock-in requirement, at the time of their enrollment. MAP has seen countless individuals who were encouraged to sign enrollment forms they could not read or understand. We find that the frail elderly and non-English speaking beneficiaries are especially vulnerable to enrollment problems:

Agnes B.

Agnes B. is 74 years old, lives alone, and has a fifth grade education. About one year ago, an FHP representative came to Mrs. B.'s house uninvited. The representative attempted

to enroll Mrs. B. in FHP, frightening her by telling her that Medicare would not be in existence too much longer.

Mrs. B. was confused and did not understand what was being presented to her. She thought FHP was a form of life insurance. Although she told the representative she was not interested, the woman was very persistent. Mrs. B. asked the representative to contact her daughter to discuss the matter. She felt sure her daughter would also advise against enrolling.

Before leaving, the representative asked Mrs. B. to sign a form stating only that the representative had been to her home and had explained the plan to her. Mrs. B. did not understand that the form she was signing was actually an enrollment form. Due to this deception, Mrs. B. did not realize she had been enrolled in FHP. She received no membership card nor notification of the enrollment. She only learned of her enrollment through Medicare denials after using out-of-plan services. MAP filed a request for a Reconsideration Hearing after FHP denied liability for these claims. Mrs. B. now has creditors dunning her for the bills she is unable to pay.

Beneficiaries are frequently harmed by HMO marketing problems. Persons who are unaware they are enrolled in an HMO or think that they have purchased an insurance policy to supplement Medicare coverage continue to use non-HMO medical providers. Typically they learn of their HMO enrollment when their claims are denied by Medicare. As a result, these individuals are sometimes forced to pay substantial medical bills.

HCFA ENFORCEMENT AND MONITORING OF HMO MARKETING PRACTICES

Inadequate Enforcement of Medicare HMO Regulations

HCFA has not been rigorous in its enforcement of Medicare HMO regulations designed to protect beneficiaries from marketing abuse.

As the recent Office of Inspector General ("OIG") study on Florida HMOs found, HCFA has not developed a data collection system that would record and track beneficiary

complaints about HMOs in any meaningful way.[2] HCFA's current primary source of information, the Beneficiary Inquiry Tracking System, only documents that an HMO inquiry has been filed with the Regional Office. Inquiries are not categorized or aggregated by type of problem, question or HMO. Without an accurate data source, HCFA can only rely on anecdotal information to assess HMO compliance with marketing regulations.

HCFA monitoring reports provide additional evidence that HCFA monitoring has been ineffective in ensuring HMO compliance with marketing regulations. In a 1988 monitoring report of FHP, HCFA expressed concern with (1) "the number of allegations received from Medicare beneficiaries of abusive marketing practices by plan representatives" and (2) "the large number of inquiries from FHP members indicating that they did not understand the lock-in or did not even know that they had enrolled in the plan." A 1990 HCFA monitoring report of FHP notes that although the overall number of complaints has lessened, the marketing problem had not been corrected and that beneficiaries continue to contact HCFA about FHP's improper marketing practices.

Unfortunately, these documented and clear violations of federal law are handled on an ad hoc basis at the Regional Office with limited acknowledgement of evident systemic problems.

Further proof of HCFA's failure to use enforcement mechanisms to ensure HMO compliance with Medicare law is shown by Region IX's extensive use of a process called "retroactive disenrollment" to remedy the consequences of improper HMO marketing

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[2] Department of Health and Human Services, Office of Inspector General, Marketing Practices of South Florida HMOs Serving Medicare Beneficiaries, Draft, May 1991.

practices. Approximately five years ago, HCFA Region IX began to see increasing numbers of beneficiaries who had used non-HMO services after enrolling in an HMO. These individuals did not know they were in an HMO or did not understand the lock-in requirement. In these cases, retroactive disenrollment was designed by HCFA to provide relief to beneficiaries who would otherwise be financially liable for out-of-plan medical bills. When retroactive disenrollment is approved, Medicare, not the HMO, is finacially liable for the out-of-plan services. MAP has found that HMOs frequently recommend retroactive disenrollment to avoid liability for their marketing abuse and that HCFA frequently approves such requests.

MAP recognizes that HCFA has used retroactive disenrollment as a safety net to aid beneficiaries. However, the availability of the process has also permitted HCFA and the HMOs to use a bandaid strategy to specific instances of HMO marketing abuse rather than to address systemic problems.

Adequacy of Existing Law to Prevent and Address Improper HMO Marketing Practices

Until very recently, HCFA's ability to ensure compliance with Medicare law heavily depended on HMOs' willingness to cooperate. HCFA had failed to promulgate regulations authorizing intermediate sanctions such as monetary penalties and suspension of enrollment payments for violation of Medicare marketing regulations. Short of terminating an HMO contract, HCFA could do little to require HMO compliance.

HCFA now has the authority to use intermediate sanctions to ensure HMO compliance with marketing laws. However, HCFA's proposed regulations regarding such sanctions provide no vehicle for HCFA to learn of and investigate beneficiary complaints.

HCFA must implement such a system and apply its new regulatory authority in order to significantly improve enforcement and compliance with marketing laws and regulations.

MARKETING RECOMMENDATIONS

The Medicare Advocacy Project makes the following recommendations for improving HCFA enforcement of current marketing regulations:

- Develop a HCFA data base that will provide aggregate and HMO specific information on HMO marketing complaints and their resolution;
- Ensure that all marketing materials approved by HCFA comply with Medicare requirements; and
- Provide more detailed instructions in the Medicare HMO Manual concerning inappropriate HMO marketing.

In addition, we request that Congress consider the following legislative approaches to protect Medicare beneficiaries from inappropriate HMO marketing activities:

- Prohibit the practice of HMO in-home marketing;
- Establish training and monitoring standards for HMO marketing activities; and
- Require that HMOs observe a three day cooling off period, during which time beneficiaries can cancel an application.

HMO QUALITY OF CARE PROBLEMS

Background

Financial incentives exist within the HMO capitation system that may encourage HMOs to provide less medical care than is needed. This is especially true for primary care

physicians or HMO contracting medical groups who are at financial risk if they refer HMO patients for hospital or specialty services. MAP has seen many incidents of very serious HMO quality of care problems, including the denial of medical treatment and access barriers to needed services.

These incidents also raise serious concerns about: (1) how well HMOs monitor the quality of care they provide to their Medicare enrollees; (2) the lack of adequate and immediate redress for beneficiaries who believe they are being denied needed care; and (3) the adequacy of governmental oversight of Medicare risk contract HMOs.

Denial or Delay in Obtaining HMO Referrals for Specialty Services and Elective Surgeries

MAP has assisted numerous Medicare HMO enrollees who have had difficulty obtaining referrals to specialists. In some cases, the HMO medical group or primary care physician inappropriately refused to refer the enrollee for needed specialty services, indicating that the services were not medical necessary. In other situations, the individual had no difficulty obtaining the referral, but experienced long delays in scheduling an appointment. A recent survey of southern California Medicare advocates revealed that in Orange County, scheduling delays of six to eight weeks are not uncommon.

HMO denials and delays harm Medicare enrollees. For example, an elderly enrollee was denied specialty services after suffering a stroke. Over a four month period, his health rapidly deteriorated because his condition had not been appropriately diagnosed or treated. Concerned that his health might suffer irreparable damage, his family had him change HMO medical groups. The last HMO physician who treated him acknowledged that the patient "had fallen between the cracks" and that it was too late for medical treatment.

MAP often sees a similar pattern of denial or delay in the area of elective surgery services. In one recent case, an HMO ophthalmologist recommended surgery for an elderly enrollee with advanced cataract disease. The enrollee's primary medical group overrode the opthalmologist's recommendation for immediate surgery. Upon investigation, MAP learned that, even when approved, the waiting time for cataract surgery is normally three to four months. When a MAP advocate inquired about the delay, she was told by the medical group's administrator that "cataract surgery is an elective procedure . . . we have 29 patients waiting and we are not going to do them all this month."

HMO Denial of Hospital Admissions, Skilled Nursing Facility Care and Home Health Care Coverage

The frequency with which HMOs erroneously deny access to hospitals, skilled nursing facilities (SNFs) and home health care is particularly disturbing. On behalf of the HMO, the primary care medical group often erroneously denies these services as not medically necessary. However, many of the beneficiaries whose cases MAP has investigated appear to meet the Medicare coverage guidelines for receiving this care. Mary C. is one of these cases:

Mary C.

During August 1990 Mary C., a member of Secure Horizons, was transferred from a hospital to a skilled nursing facility to receive physical therapy for the paralysis of her left leg. The HMO contracting medical group authorized payment for a two week stay. At the end of two weeks, Ms. C. and her brother were informed orally that she no longer needed physical therapy and, therefore, her nursing home stay would no longer be covered by the HMO. Distressed with the HMO determination, Ms. C's brother contacted her primary care doctor, the HMO medical group and the HMO member relations representative for assistance. Despite his efforts, Ms. C's brother was not given a written notice of noncoverage and therefore could not appeal the HMO decision.

Frustrated, Ms. C's brother contacted MAP. As a result of MAP's efforts, Secure Horizons authorized physical therapy and the nursing home stay for an additional five weeks.

When Ms. C. left the nursing home, however, she encountered problems obtaining home health care and durable medical equipment coverage from the HMO. Her HMO primary care doctor stated that he was not responsible for issuing a prescription for these services. Worried about the adverse effect of further delays on her health, Mrs. C's family obtained the services outside the HMO and filed an appeal to request reimbursement.

Information supplied by skilled nursing facilities and home health providers who contract with HMOs also shows the pattern of erroneous HMO denials of skilled nursing care. Frequently, social workers, nursing supervisors and physical therapists comment that if the beneficiary were not in an HMO, there would be no problem obtaining Medicare coverage. In addition, providers state that when HMOs authorize extended care coverage, it is generally extremely limited and frequently insufficient. These comments are particularly significant given that SNFs and home health agencies are traditionally very conservative in their assessment of eligibility for Medicare coverage.

Seen less frequently, but enough to raise concerns, are HMO denials of hospital admissions. In one case, an HMO enrollee was taken several times to HMO physicians for repeated complaints of dizziness, nausea and general weakness. Concerned that she was dehydrated, her son asked an HMO physician to hospitalize her. The doctor stated that hospitalization was unnecessary. One day later, she was rushed to the emergency room of a non-HMO hospital and was admitted for uncontrolled diabetes.

In another recent case, an HMO enrollee in very poor health fell at home and was unable to get up. The HMO primary care physician refused to authorize an ambulance to take her to the hospital. When she fell a second time and was unconscious, the HMO

physician authorized transport by ambulance only after the family threatened him with a lawsuit and a complaint to the licensing authority. Even then, the HMO physician refused to admit her to a hospital for evaluation. Instead, he sent the patient directly to a skilled nursing facility, where she died a few days later.

WHY HMO QUALITY OF CARE PROBLEMS OCCUR

Quality of care problems occur for several reasons. A key factor is the financial incentive for HMOs and their contracting medical groups and physicians to underserve Medicare beneficiaries. Other factors include lack of HMO oversight of contracting medical groups and facilities; lack of HCFA oversight of HMOs; absence of an expedited review process for quality of care problems; and lack of HMO quality of care data.

Lack of HMO Oversight of Contracting Medical Groups and Facilities

Repeated incidents of similar HMO quality of care problems indicate poor HMO oversight of contracting medical groups and facilities. HMO quality assurance programs (QAPs) are designed to ensure the provision of quality care. However, as reported in the recent General Accounting Office ("GAO") study of PRO oversight of HMO quality of care, HMO quality assurance programs frequently have serious weaknesses that also violate federal regulations.[3] In addition, patterns of quality of care problems with specific providers indicate that HMOs are failing to adequately oversee their contracting medical groups.

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[3] General Accounting Office, Report to the Ranking Minority Member, Special Committee on Aging, U.S. Senate, Medicare PRO Review Does Not Assure Quality of Care Provided by Risk HMOs, March 1991.

Transfer of Financial Risk to HMO Contracting Providers

In a very significant number of quality of care cases, the decision not to provide medical treatment strongly appeared to be based on financial considerations. In these cases, the cost for medical care would have been the responsibility of the contracting medical group, not the HMO. The transfer of financial risk from the HMO to the physicians who make decisions about patient access to care creates a troubling conflict of interest.

Lack of HCFA Oversight of HMOs

HCFA has retained PROs to oversee HMO quality of care. However, PROs currently do not have the authority or information needed to do so effectively. In California, consumer complaints filed with the PRO take months to investigate and consumers gain no effective relief. Beneficiaries who complain of quality of care problems are given at best minimal information about the PRO's findings and no information at all as to how or whether the problem has been corrected. In at least one other state, the PRO has stated that its role does not even include investigating complaints by beneficiaries.

Absence of an Expedited Review Process to Investigate Quality of Care Problems

Generally, Medicare beneficiaries who experience HMO quality of care problems are in an urgent or emergency situation. Failure to resolve these problems may adversely affect the beneficiary's health.

Unfortunately, Medicare HMO enrollees do not have access to an expedited review process that will remedy quality of care problems. The Medicare HMO appeals process, designed primarily to determine financial liability for already incurred medical bills, allows an HMO sixty days to make its initial determination. Most quality of care problems cannot

wait that long. Therefore, beneficiaries often disenroll from the HMO in order to obtain needed care in the fee-for-service sector, thus relieving the HMO of further expense. In reality, then, Medicare HMO enrollees have no protection against, or any meaningful way to resolve, HMO quality of care problems.

Lack of Quality of Care Information

Quality of care data is not collected in a manner that can be effectively used by HCFA to monitor HMO quality of care. As the GAO reports in its study on PRO oversight of HMOs, external review of HMO inpatient utilization data is affected by significant reporting problems. Even more serious, current review of HMO ambulatory care is not possible because of the absence of a centralized data base.

To date, HCFA has not collected beneficiary complaints about HMO quality of care as a means of assessing HMO quality and compliance with Medicare law. The Beneficiary Inquiry Tracking System does not even have the capability to provide detailed aggregate information on beneficiary complaints. Therefore, although mandated by law to ensure HMO quality of care, HCFA has failed to collect beneficiary complaints in a manner that would enable effective monitoring of HMOs, much less to address such problems on a systemic basis.

Finally, Medicare beneficiaries lack access to any meaningful HMO quality of care data. Thus, they have no way of comparing the many HMOs urging them to enroll. Too often, beneficiaries choose an HMO based on which of the HMOs' marketing agents are most persuasive. Medicare beneficiaries lack information on utilization of services, how long enrollees have to wait to get a specialty appointment, and the number of complaints filed

against each HMO. This information would help beneficiaries make an informed choice about HMO enrollment.

HMO QUALITY OF CARE RECOMMENDATIONS

The Medicare Advocacy Project makes the following recommendations for improving quality of care in the HMO capitated system:

- Place restrictions on the level of financial risk HMOs can assign to HMO contracting physicians and medical groups;
- Create an expedited HMO quality of care review process;
- Encourage HMOs to have a quality of care ombudsperson who is responsible for investigating and resolving reported quality problems;
- Restructure the Beneficiary Inquiry Tracking System to collect beneficiary quality of care complaints by category and by HMO;
- Require HMOs to report hospital, skilled nursing facility and home health care utilization data to the PROs;
- Require HMOs to collect and report ambulatory care utilization data to the PROs;
- Develop a comprehensive data base that would integrate data from PRO quality reviews, the HCFA compliance monitoring process and the Beneficiary Inquiry Tracking System, to create quality of care profiles on Medicare risk contract HMOs; and
- Make HMO quality of care data available to Medicare beneficiaries and their advocates.

HMO APPEALS PROCESS

The Medicare HMO appeals process is flawed and does not adequately protect beneficiaries' rights. The deficiencies of the appeals process are exacerbated by inconsistent

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HMO compliance with Medicare legal requirements and significant abuse of the appeals process by HMO contractors.

Defects in the Appeals Process

The HMO appeals process is difficult to use as well as ineffective in protecting beneficiaries' rights. Even with time lines at every phase of the process, it is cumbersome and slow. Moreover, the process is marred by obvious conflict of interest factors. Although the HMO has a clear financial interest in the outcome of the appeal, the HMO, rather than an impartial party, is responsible for coverage determinations at the first two stages of the appeal. Furthermore, unlike the Medicare fee-for-service appeals process, the HMO procedures afford enrollees no protection against premature hospital discharge. And, as discussed above, there is no mechanism to deal with emergency and urgent quality of care problems.

Inconsistent HMO Compliance with Medicare Legal Requirements

Medicare regulations require that HMOs make coverage and claim decisions within specific time limits. Due to litigation, HMOs have improved their compliance with appeals process requirements. Nevertheless, serious problems persist. First, HMO contracting providers make the initial claim or coverage decisions. Second, although providers frequently fail to make determinations in a timely fashion, HMOs generally refuse to take any action to remedy the situation. Complaints filed by MAP that deadlines have long passed without any determination issued are ignored or "referred to the appropriate department for review." Failure to ensure compliance with the law reflects a clear breakdown in HMO accountability to its Medicare enrollees.

Finally, HMOs often arbitrarily and erroneously deny non-HMO urgent and emergency care as not medically necessary. In one case, an elderly enrollee was taken to the hospital by paramedics after her apartment manager found her disoriented and with a badly swollen leg. The hospital staff contacted her HMO physician who refused to admit her. After stabilizing her condition, the hospital released her. The HMO has denied payment of her claim and she is appealing the decision. In another case, the emergency room of a non-HMO hospital obtained authorization to treat an HMO enrollee for shortness of breath; an EKG showed that the patient had arrythmia. However, the HMO later denied payment of this claim, forcing the enrollee to appeal.

When HMOs routinely deny non-HMO emergency and urgent care claims, HMO enrollees are unfairly forced to appeal claims that should be covered under their HMO contract. Beneficiaries who are unable to handle an appeal due to advanced age or illness must pay for services that should be covered.

Significant Abuse of Appeals Process by HMO Contracting Providers

In addition to the problems of exceeding appeals process time lines and routinely denying non-HMO emergency and urgent care claims, HMO contracting providers frequently fail to issue a written denial when making an HMO coverage determination. This practice has critical significance: without a written denial, a Medicare enrollee cannot appeal the denial of care or payment. Therefore, the appeals process provides no beneficiary protection if HMO provider practices deliberately undermine its effectiveness.

HCFA Oversight Plagued by Weak Enforcement Capability

In the past, complaints filed with HCFA were investigated only on a case by case

basis. However, recent discussions with the HCFA Region IX office indicate that HCFA is aware that some HMOs are seriously violating federal regulations. What corrective action HCFA will take, if any, to remedy these systemic problems is still unclear.

APPEALS PROCESS RECOMMENDATIONS

The Medicare Advocacy Project makes the following recommendations for improving the HMO appeals process:

- Provide Medicare HMO enrollees with the same appeal rights afforded Medicare beneficiaries in the fee-for- service sector;
- Provide HCFA with authority to impose intermediate sanctions for HMO failure to pay for non-HMO urgent and emergency care; and
- Provide HCFA with the authority to impose intermediate sanctions to ensure that HMOs comply with the legal requirements of the HMO appeals process.

CONCLUSION

Serious HMO marketing, quality of care and appeals process problems adversely affect Medicare HMO enrollees' access to quality health care. Without aggressive HCFA monitoring and enforcement, these systemic problems will continue unchecked and beneficiaries will remain unprotected.

MAP Medicare Advocacy Project
MAKING SENSE OF MEDICARE

ATTACHMENT I

HMO CLIENT PROBLEMS

HMO MARKETING ABUSE

Blanche C.

Blanche C. is a 71 year old Medicare beneficiary. In May of 1991, responding to a request for additional information on the Family Health Plan ("FHP") Senior Plan, an FHP marketing agent visited her in her home. After listening to his presentation, Ms. C. told the representative that she was not interested in enrolling. She later threw away the information the marketing representative had left behind.

Much to her surprise, Ms. C. learned she was enrolled in FHP when Medicare began denying her claims due to HMO enrollment. Ms. C. contacted MAP to investigate her FHP enrollment. MAP filed an inquiry with FHP and forwarded a copy of Ms. C.'s enrollment records to her. Ms. C. contends that the signature on the form was not hers and was evidently forged.

On her behalf, MAP filed a marketing complaint. Following an investigation, FHP determined that there was no evidence of fraudulent enrollment but, nevertheless, agreed to pay any Medicare denied claims that date to the period of Ms. C.'s enrollment in FHP. The signature on the enrollment form appears quite different from Ms. C.'s signature.

Agnes B.

Agnes B. is 74 years old, lives alone, and has a fifth grade education. About one year ago, an FHP representative came to Mrs. B.'s house uninvited. The representative attempted to enroll Mrs. B. in FHP, frightening her by telling her that Medicare would not be in existence too much longer.

Mrs. B. was confused and did not understand what was being presented to her. She thought FHP was a form of life insurance. Although she told the representative she was not interested, the woman was very persistent. Mrs. B. asked the representative to contact her daughter to discuss the matter. She felt sure her daughter would also advise against enrolling.

Before leaving, the representative asked Mrs. B. to sign a form stating only that the

representative had been to her home and had explained the plan to her. Mrs. B. did not understand that the form she was signing was actually an enrollment form. Due to this deception, Mrs. B. did not realize she had been enrolled in FHP. She received no membership card nor notification of the enrollment. She only learned of her enrollment through Medicare denials after using out-of-plan services. MAP filed a request for a Reconsideration Hearing after FHP denied liability for these claims. Mrs. B. now has creditors closing in on her for the bills she is unable to pay.

Tomiko T.

Ms. T. is 76 years old and suffers from senile dementia. Ms. T. enrolled in FHP in January 1991, but does not appear to understand what enrollment in FHP means. Six months after enrolling in FHP, she was mugged and knocked unconscious. Paramedics took her to the nearest hospital emergency room for care. The hospital claims were paid because it is an FHP contracting facility.

However, Ms. T. has continued to use the same doctors she has seen for the past ten to twenty years. These doctors are not FHP doctors. When her doctors realized she had enrolled in FHP, they notified Ms. T.'s daughter who had no prior knowledge of her enrollment. Ms. T. currently has almost $20,000 in unpaid bills for out-of-plan office visits and services. With MAP's help, Ms. T.'s daughter filed an appeal with FHP.

Ms. T. has no recollection of signing FHP enrollment forms and when asked about lock-in, clearly still not does understand this provision of HMO enrollment. Moreover, as her vision is very poor, she likely was unable to read the enrollment form she signed. The FHP representative should easily have recognized her confusion.

Ms. T. currently has almost $20,000 in unpaid bills from out-of-plan office visits and services.

John B.

John B. was 57 years old when he enrolled in Family Health Plan (FHP), a Medicare risk-contract HMO, on April 11, 1990. He had Medicare coverage due to permanent, total disability. He also had a Medicare supplemental policy through the Retiree Plan of the Motion Picture Health and Welfare Fund, at no cost to him, as a disability retirement benefit.

Mr. B. enrolled in FHP after he listened to a presentation of the Senior Plan made in his home by an FHP representative. His wife, Mrs. B, was not present during most of the discussion that took place between her husband and the representative, but did hear the last part of it.

Mr. B. had recently suffered a stroke and is being cared for at home by Mrs. B, who also holds a full-time job. The Bs. explained to the FHP representative that they were under

extreme stress because of the unrelated deaths of two of their children and the poor health of a third child. They further explained that their only interest in FHP was in obtaining more home health care beyond was provided by Medicare and their Motion Picture coverage. **The FHP representative said that FHP "worked along with Medicare," and that FHP would provide them with the home health services they needed.** She then very rapidly read through the "Statement of Understanding" and Mr. B. initialed it.

The representative did tell the Bs. about using only FHP providers for FHP services, but did not explain the co-payments for doctors and prescriptions. Mr. B's Motion Picture supplemental policy provided coverage for his Medicare co-payments, in addition to prescription drug coverage.

The representative told the Bs. that FHP membership could be terminated at any time and that all they had to do was call her.

After reading the literature left by the representative (and learning about the co-payments and lack of additional home health benefits) the Bs. decided to disenroll Mr. B. They called the representative as they had been instructed to do; their phone calls were never returned. Mrs. B finally reached a FHP supervisor who took Mr. B's. Social Security number and said that he would have Mr. B disenrolled.

In June of 1990, Mr. B. suffered another stroke. Believing that he was not an FHP member, he sought care outside of the plan. FHP denied his out-of plan claims for $28,500.

Mr. and Mrs. T.

Mr. and Mrs. T are eligible for both Medicare and Medi-Cal., Mr. and Mrs. T are Latino and their primary language is Spanish. When contacted by an HMO marketing agent, Mr. T was in poor health: He requires continuous medical care for diabetes, has impaired vision, and was recovering from a stroke.

The agent argued that the HMO provided better coverage than that provided by Medicare and Medi-Cal because it would save them money. Because Mr. and Mrs. T had both Medicare and Medi-Cal coverage, this statement was inaccurate. Although the Ts told the agent that they were satisfied with their current coverage, the agent insisted that his HMO would be better for them and that Mr. and Mrs. T. would be foolish ("no sean tontos") not to enroll.

Mrs. T felt extremely pressured by the agent who was in her home for an hour and a half. She believed that he would not leave until she enrolled. When the agent told her that she could cancel the enrollment within three days, she decided to sign the HMO forms. At no time did the agent ask Mr. and Mrs. T to read what they signed.

Within the three day cancellation period, Mrs. T called the agent to say that she did not

want to be enrolled in the HMO. Although the agent was not in, the HMO representative with whom she spoke took her name and said that Mr. and Mrs. T would be disenrolled.

Thinking that they were disenrolled, the Ts continued to use non-HMO providers. Mr. T. was hospitalized for his diabetes, and Mrs. T. made several visits to her podiatrist. Subsequently, Medicare sent notice to the Ts that it would not pay for this care and that the Ts owed their hospital and physicians over $20,000.

Mrs. T made several trips to the HMO to try and disenroll, but never received a disenrollment form. HMO translators were not available to help Mrs. T and, in addition, the marketing representative came to the Ts home again to urge them not to disenroll.

It was not until the Ts were referred to the Medicare Advocacy Project that they received help. A staff person at the Medicare Advocacy Project was able to get the Ts retroactively disenrolled from the HMO. Medicare paid their bills of over $20,000.

Rosemarie T.

Ms. T. is a 78 year old Medicare and Medi-Cal beneficiary who was enrolled in FHP on July 1, 1990. Ms. T's involvement with FHP began when she responded to an FHP print advertisement. An FHP marketing representative telephoned and she agreed to have a representative come to her home.

The marketing agent did not explain to Ms. T. how FHP membership would relate to her Medicare and Medi-Cal benefits: "We talked it over quite a bit but he assured me it was just something extra--added to my Medicare. Medi-Cal was not involved." Thus, he failed to inform her that she would have to use FHP providers for all her Medicare-covered services and that her Medi-Cal benefits, which are secondary to Medicare, would also be directly affected.

Furthermore, Ms. T. states that the FHP representative told her she could continue using her own doctors. Ms. T did sign the enrollment forms, but was told that these were "just an application." In addition, the representative did not provide any instructions about disenrollment. Not understanding she was enrolled in FHP, Ms. T was hospitalized for an acute myocardial infarction at a non-FHP hospital. Her medical bills total over $44,000 (see Attachment B).

Ollie T.

Mr. T. is a 78 years old African American. Mr. T. states that an FHP marketing representative came to his home in October 1990 and "tried to get me to join FHP." The FHP representative was very persistent and told Mr. Thomas that he wouldn't have to pay anything to be in FHP." Mr. T. says he told the representative that he had been with Kaiser for 15 years and that he was happy with the plan. He told the representative that he "did

not want to leave Kaiser."

The marketing agent asked Mr. T. to sign a paper to document that she had been out to his home. Unfortunately, the form Mr. T signed was an enrollment form, not as the marketing agent claimed, a notice of the visit. Mr. T. did not read the form before signing because he says he was not interested in FHP and only signed to show that the FHP representative had been to his home. After obtaining Mr. T.'s signature, the FHP representative told him she needed to get her business card and other papers from her car and would be right back. The agent went to her car and never returned. She left neither her business card or copies of the forms she had convinced Mr. T. to sign.

Sometime in April 1991, Kaiser notified Mr. Thomas that he owed approximately $1000.00 in back premiums because he was no longer in their Medicare plan. This was the first notice that Mr. T. had that he was enrolled in FHP.

HMO-DENIAL OF EMERGENCY CARE COVERAGE

Lucy H.

Lucy H. is a 70 year old Latina with Diabetes. English is not her first language. In September of 1988 Ms. H. was taken to the closest emergency room by her family after they found her unconscious in her bathroom. At the time, her family was unaware of Ms. H.'s enrollment in Secure Horizons, and thus did not contact the HMO.

At the emergency room doctors found it necessary to amputate part of Ms. H.'s foot due to gangrene. When the hospital discovered that Ms. H. was enrolled in Secure Horizons, she was stabilized and transferred to a Secure Horizons hospital where she stayed for three weeks. Secure Horizons subsequently denied payment for the emergency room services provided by the non-HMO hospital due to lack of prior authorization.

Approximately one week after being discharged, Ms. H. became very dizzy at her niece's home. She was again taken to the closest emergency room. Once stabilized, she was transferred, with authorization, to a Secure Horizons hospital and nursing facility where she remained for one week. Again, Secure Horizons denied the emergency room bill due to lack of prior authorization.

Ms. H. and her family have spent a great deal of time and effort trying to resolve the $1,728.44 emergency room bill. By the time the family contacted the Medicare Advocacy Project, collection agencies were threatening Ms. H.

Rachel C.

Mrs. C. is an 80 year old enrollee of United Health Plan ("UHP"). In October of 1990, UHP authorized paramedics to transport Mrs. C. from her home to the nearest hospital

emergency room. She was later transferred to a UHP facility. Nevertheless, Mrs. C.'s medical group has denied the emergency room claim.

The denial notice issued to Mrs. C. failed to state the specific services being denied or provide an explanation of the basis of denial, making it impossible for Mrs. C. to know what action she should take.

Mrs. C. has persistently resubmitted the bills to UHP which has promised to "take care of it." Despite these assurances, the HMO has failed to meet deadlines established by the Medicare HMO appeals process. The MAP has assisted Mrs. C. in contacting her HMO and medical group as well as in the appeals process. In the interim, Mrs. C. is being threatened with legal action by collection agencies.

Angelina F.

While visiting Connecticut in May 1991, Ms. F., a member of UHP, needed urgent care when her leg swelled. She visited a local doctor, who referred her to an emergency room for treatment. The emergency room physician treated her for a bad leg infection and sent her home to recuperate.

Upon her return to California, Ms. F. promptly hand delivered her bills for urgent care to her HMO medical group for review. Ms. F. was told that the claims would be properly forwarded. When she called to follow up on the status of the review several weeks later, she was informed that the medical group had no record of her claims.

Ms. F. resubmitted her claims to the medical group two additional times. She also submitted her claims directly to the HMO before contacting MAP. MAP representatives filed an HMO appeal in order to expedite a review of the claims. However, the HMO refused to review the claims even though the medical group had failed to issue a claim determination within the time frame required by Medicare law.

Months after filing her claims, Ms. F. has finally received payment of some of her claims. However, the HMO medical group is still holding up payment consideration on some claims until it receives additional medical records from Connecticut.

SKILLED NURSING FACILITIES

Mary C.

During August 1990, Mary C., a member of Secure Horizons was transferred from a hospital to a skilled nursing facility to receive physical therapy for the paralysis of her left leg. The HMO contracted medical group agreed to authorize payment for a two week stay. At the

end of two weeks, Ms. C. and her brother were informed verbally that she no longer needed physical therapy and, therefore, her continued nursing home stay would no longer be covered by the HMO. Distressed with the HMO determination, Ms. C's brother contacted her primary care doctor, HMO medical group and the HMO member relations representative for assistance. Despite his efforts, Ms. C's brother was not given a written notice of noncoverage and could, thus, not appeal the HMO decision.

Frustrated, Ms. C's brother contacted MAP. MAP contacted Secure Horizons and requested that the HMO investigate the situation. As a result, Secure Horizons agreed to continue authorization of the physical therapy and the nursing home stay for an additional five weeks.

When, Ms. C left the nursing home, however, she encountered problems obtaining home health and durable medical equipment coverage from the HMO. Her HMO primary care doctor stated that he was not responsible for issuing a prescription for these services. Worried about further delays, her family obtained the services outside the HMO and filed an appeal to request payment.

Ludwig S.

Mr. S. was 92 years old member of UHP when he was admitted to a UHP contracting hospital in 1990 with cellulitis of the left arm. Upon discharge, his doctor prescribed antibiotics to be administered intravenously in a skilled nursing facility (SNF). Mr. S. was told that his SNF stay would be covered by UHP. However, upon arrival at the facility, the nursing home told his wife, Mrs. S., that another doctor had changed the prescription to oral antibiotics. As a result, Mr. S's stay was now considered custodial, and not covered by UHP. Mrs. S. was unable to care for her husband at home and was forced to pay a $2300 deposit for her husband's continued stay at the facility.

Neither UHP or the SNF issued a written notice to Mr. S informing him of his appeal rights. MAP filed a complaint with UHP regarding its failure to provide adequate appeal right notice to Mr. S.

Although initially interested in pursuing an appeal, Mrs. S decided against seeking UHP payment of the nursing home charges when her husband died.

HOSPITAL DISCHARGE

Ethel B.

Ethel B. is 88 years old and lives alone. She is a member of Secure Horizons and was recently admitted to a participating Secure Horizons hospital. Her family grew concerned one morning when the attending doctor informed it that Ms. B. would be discharged that

same afternoon. The doctor did not return numerous phone calls made by family members. Because Ms. B. lives in public housing, a note from the doctor stating it was safe for her to return home was required. Ms. B.'s family felt she was not ready to go home and that the decision had been made abruptly. No one had discussed the situation with the family prior to making the discharge decision.

Upon investigation, MAP learned that a discharge plan had not been carefully worked out and that there was a general lack of communication between the doctor and family. The physical therapist involved felt that more time was needed for an evaluation of the client's condition and need for skilled nursing care.

Fortunately, Secure Horizons has recently employed an intervention nurse to provide assistance in emergency situations. The nurse helped Ms. B.'s family and MAP in the resolution of this situation and is investigating the complaints made.

ATTACHMENT II

M/C Research

[redacted]
TEMPLE CITY, CA [redacted]

Dear Senior:

Here's your chance to give us some information on your medical insurance costs, and the quality of health care you receive. Your opinions and answers to this survey could make a difference for you and other Medicare beneficiaries in Southern California.

The survey is being sponsored by a major health care provider concerned with improving the quality of health care for seniors like you.

As you will see when you turn to the next page, all questions can be answered simply by filling in a box with any standard pencil or pen.

After you have completed the survey, fold it and mail it back to us in the enclosed reply envelope as quickly as possible. Postage has already been paid.

Thank you for completing the survey.

Sincerely,

Craig P. Campbell
M/C Research

P.S. When the questionnaires have been tallied (in about 6 weeks), we will give you information on the results of this survey.

INSTRUCTIONS
PLEASE READ THIS BEFORE YOU BEGIN.

Using a pencil or pen, fill in the box next to the answer that is closest to your opinion. If you do not have an opinion on any topic, simply go to the next question.

Please write your phone number here: (____) _____

SECTION ONE:

1. Do you have Medicare Part A (for hospital bills)? ❑ Yes ❑ No

2. Do you have Medicare Part B (for doctor's fees)? ❑ Yes ❑ No

3. Do you have a supplemental health insurance plan? ❑ Yes ❑ No

4. If you have a health insurance plan, how much do you pay annually in premiums? (Skip to next question if you do not have supplemental insurance.)
   - ❑ Under $100
   - ❑ $100-$350
   - ❑ $351-$500
   - ❑ $501-$750
   - ❑ $751-$900
   - ❑ Over $900

5. How much do you pay out of your pocket for each doctor office visit?
   - ❑ Under $10
   - ❑ $10-$25
   - ❑ Over $25

6. How much do you pay out of your pocket monthly for prescriptions?
   - ❑ Under $10
   - ❑ $10-$25
   - ❑ $26-$50
   - ❑ $51-$75
   - ❑ Over $75

7. Are your health care benefits provided as part of your retirement benefits? ❑ Yes ❑ No

8. If health care is part of your retirement benefits, how much are you required to pay every year?
   - ❑ $0-$500
   - ❑ $501-$1000
   - ❑ More than $1000

9. Have you had to take money from your savings to pay for medical care? ❑ Yes ❑ No

10. Are you a member of a health maintenance organization (HMO)? ❑ Yes ❑ No

11. Do you know that people over age 65 and entitled to Medicare, can join a health maintenance organization (HMO) which contracts with Medicare to provide services to Medicare beneficiaries with all Medicare services covered and additional services offered at little or no additional cost? ❑ Yes ❑ No

SECTION TWO:

12. I have to sit a long time in the waiting room before I see my doctor. ❑ Yes ❑ No

13. My doctor's office is convenient. ❑ Yes ❑ No

14. I think my doctor is:
   - ❑ Excellent
   - ❑ Good
   - ❑ Fair
   - ❑ Poor

15. I have been seeing my family doctor for:
   - ❑ Less than 1 year
   - ❑ 1-4 years
   - ❑ More than 4 years

16. My doctor's fees have increased a lot in the last five years. ❑ Yes ❑ No

17. When I feel ill I sometimes wait to see if I will get better instead of calling the doctor right away. ❑ Yes ❑ No

18. I have a routine checkup every year even if I am not ill. ❑ Yes ❑ No

19. I worry a lot about whether or not all my savings will end up being spent on medical care. ❑ Yes ❑ No

20. My age is:

❑ Under 65
❑ 65-69
❑ 70-74
❑ 75-79
❑ 80-84
❑ Over 84

IMPORTANT. WHEN YOU HAVE COMPLETED THE QUESTIONS, FOLD THE SURVEY AND MAIL IT TO US IN THE RETURN ENVELOPE ENCLOSED. POSTAGE IS ALREADY PAID.

THANK YOU FOR HELPING US.

Mr. WAXMAN. Thank you.
Ms. Torgan.

STATEMENT OF SYLVIA TORGAN

Ms. TORGAN. Thank you, Mr. Chairman, for giving me the opportunity to speak to you today.

I also want to thank Congressman Larry Smith, who has cooperated with our HMO Patient Advocate Committee for his outstanding performance in pursuing this most important issue.

I also want to say that it is not the intention of our committee to dismantle the HMO's. On the contrary, we believe they perform a very important function, specifically for the elderly, who very often have to choose between buying food and paying for their costly medications which the HMO does provide.

I have been a social worker for 19 years, and in that role, I have been a advocate for the elderly. In south Florida, I was made aware of problems that exist in the Medicare HMO system and founded the HMO Patient Advocate Committee to address serious deficiencies in quality of care.

In the past year, our committee has received over 50 complaints from HMO patients, most pertaining to quality of care. In almost half the cases, we assisted the patients in writing complaints to appropriate regulatory agencies.

In many cases, the patient or family member said you are my last hope, having spent hours or days trying to get help with their problem.

All cases showed a pattern of deprivation of medical care, delay or denial of necessary medical care by a specialist, refusal to order appropriate laboratory or x-ray testing medical referrals and other medical services being submitted to an administrator for approval rather than being the sole responsibility of the physician, refusal to authorize hospital admissions, premature discharge from hospital and/or inadequate posthospital followup, discharge planning not properly implemented by HMO personnel with little or no effort to utilize communities resources for continuing care, long delays in getting appointments, doctors who see more than 30 patients a day.

We feel many of the above-listed abuses are a direct result of the capitation system and financial incentives for under utilization of medical services, to put the physician at financial risk or to offer bonus payments based on excessive rationing of medical services is, at best, a serious conflict of interest. Perhaps full disclosure of these financial arrangements would allow consumers to decide if this is an acceptable arrangement.

There are other methods of payment available less likely to lead to abuse. It is our understanding that a Medicare HMO enrollee should not receive any less coverage than Medicare guidelines allow. It has been our experience, this not the case.

The experience of two local hospitals indicates a pattern of noncompliance for some HMO patients. Further, Medicare HMO enrollees are denied the right to immediate review by an outside agency where a patient is in jeopardy of premature discharge from the hospital. Patients are discharged with high fevers; open, infect-

ed wounds; cast placement prohibiting most movement; or with deteriorated mental status likely to injure themselves if left alone.

Grievance procedures are cumbersome and may take upwards of 30 days. Responsibility for the problem can be difficult to place. Elusive standards of care are the criteria used to judge validity of complaints.

In our experience, we are very uncomfortable accepting the treatment we have been told of as being reasonable standards of care in our community. HMO self-imposed quality assurance is, in our opinion, inadequate.

We note that the current administration strongly endorses managed health care. There must be adequate provision made to protect patients in any managed care system where medical services are looked at from a cost-effective point of view to provide profits for management and shareholders. There is a serious need for immediate review of quality-of-care issues, as well as monitoring of those grievances made directly to the HMO.

Concerned citizens are effective advocates of the rights of others. Therefore, we have proposed a bill to the Florida legislature to create a ombudsman committee to review certain complaints in order to prevent needless suffering. Only by an independent, third party investigation, with followthrough to see what action was taken to address these grievances, will we ensure true quality of care.

Thank you, and I will receive questions.

[Testimony resumes on p. 94.]

[The prepared statement and attachments of Ms. Torgan follow:]

ENERGY AND COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

HEARING ON MEDICARE HMO PROGRAM

SUBMITTED BY: SYLVIA TORGAN, PRESIDENT
HMO PATIENT ADVOCATE COMMITTEE
BROWARD COUNTY, FLORIDA

I. INTRODUCTION.

I have been a social worker for 19 years and in that role I have been an advocate for the elderly. As a social worker in South Florida I became aware of some of the problems that exist in the Medicare HMO System. For that reason I founded the HMO Patient Advocate Committee in response to the need to address some serious deficiencies in quality of care.

II. SYSTEMATIC PATTERN OF DEFICIENCY OF CARE.

In the past year our committee, with no funding, no advertising, relying on occasional mention in local news stories and word of mouth recommendation, has received over 50 complaints from HMO patients, almost all of which pertained to quality of care. In almost half of these cases our committee assisted the patient in preparing written complaints to appropriate state and federal investigatory agencies. Some of the callers were reluctant to file a complaint after receiving information or some minor intervention on our part that helped them solve their problems. All cases, however, showed a pattern of abuse and deprivation of medical care:

A) Delay or denial of necessary medical care by a specialist, thus causing further deterioration in the patient's condition to the point where the patient may be too weak or too ill to undergo diagnostic or corrective treatment;/

B) Refusal to order appropriate laboratory or x-ray examinations thereby possibly delaying diagnosis and treatment of a life-threatening condition;

C) Medical referrals and other services being submitted to an administrator for approval rather than being solely the responsibility of the physician;

D) Refusal to authorize hospital admission with the result that patients could end up in public hospitals at public expense, We have heard a number of complaints where after the HMO refused authorization the patient was admitted anyway by a non-HMO physician due to the serious nature of their condition; in some cases hospitals must go through lengthy and costly procedures to recover payment, often at public expense;

E) Premature discharge from hospital and/or inadequate rehabilitation and home health care coverage. Discharge planning not being properly implemented by HMO personnel with little or no effort being made to utilize community resources for continuing care;

F) Long delays in getting appointments with primary care physicians; doctors who see 30 or 35 patients a day allowing 5 to 10 minutes with elderly patients who often have serious multisystem diseases; doctors refusing to return calls to patients and/or family members even in extreme situations;

We know there are more quality of care complaints than statistics show. Many patients are not informed of the grievance procedures, are intimidated after an initial telephone call to the HMO; and even being chided by their physician for complaining, leaving these patients in fear they will lose their benefits if they pursue any further complaints.

Patients routinely complain of lack of dignity in the way they are treated by HMO personnel, and being treated as "second class citizens"; in fact, the State of Florida, in its proposed changes to HMO rules, recommends they "Assure that physicians and hospitals treat all HMO (and PHC) patients with equal dignity and consideration as their non HMO (and PHC) patients."[1]

III. CAPITATION AND FINANCIAL INCENTIVES.

We feel many of the above listed abuses are a direct result of the capitation system and financial incentives for underutilization of medical services. To put the physician at financial risk, or to offer bonus payments based on excessive rationing of medical services, is at best a serious conflict of interest. Certainly the physician should be concerned with what is in the best interest of the patient, without suffering a financial penalty for doing so. It has been suggested that full disclosure of these contractual arrangements between HMO's and their physicians with reference to capitation, incentive plans for shorter hospital stays, fewer hospital admissions, and a low number of specialist referrals, would enable the consumer to consider whether this is an acceptable arrangement.[2]

We have concluded that alternate payment methods such as fee for service with appropriate utilization review would provide greater protection for the patient.

HEARING ON MEDICARE HMO PROGRAM

IV. MEDICARE GUIDELINES.

It is our understanding that if a Medicare recipient assigns his benefits to an HMO he should not receive any less coverage than Medicare guidelines allow. It has been our experience that this is not the case.

Statements from Social Service Directors in two area hospitals attest to the difficulty in obtaining appropriate home health and rehabilitation care for their HMO patients. In fact, a five month study at one hospital showed 95% of Medicare patients with a fractured hip went to inpatient rehabilitation facilities; 100% of Medicare-HMO patients with fractured hips went home or to a nursing home. Their experience indicates a pattern of noncompliance with Medicare guidelines for home health care exists for some HMO patients.[3, 4]

Further, Medicare-HMO enrollees are denied the right to an immediate review by an outside agency where a patient is jeopardy of premature discharge from hospital. We understand this was not the intent of the law; and this should be corrected immediately. HMO patients may be and in fact are being discharged from hospital on virtually an hour or two notice; several patients and/or family members have told of patients discharged home with high fevers, open infected wounds, cast placement prohibiting most movement, or patients with deteriorated mental status likely to injure themselves if left alone. If the hospital refuses to discharge the patient in serious condition, they must bear the responsibility of further hospital costs, and arrange for followup care, nursing home placement, etc., again often at public expense.

V. GRIEVANCE PROCEDURES.

For the elderly patient with an ongoing medical problem that needs prompt attention, there is no review board, regulatory agency or other advocate to investigate his grievance in a timely manner and follow through to see the patient receives necessary medical services. In fact, the patient who wants to follow current grievance procedures finds a cumbersome system requiring written complaints, forms to fill out, and numerous agencies to which he may direct his problem. Most of these government agencies take upwards of 30 days to investigate a quality of care complaint. The problem takes on massive proportions when the grievance involves an urgent medical problem and can be overwhelming to a sick, possibly confused or depressed elderly patient.

The responsibility for the problem is often difficult to place; in Florida, HRS Licensure and Certification investigates quality of care complaints against the HMO itself; if however they perceive the problem was caused by a physician who may have been following HMO guidelines, or responding to financial incentives or risks imposed by the HMO, it is deemed the physician as the caregiver is the responsible party and not the HMO. Then, when a complaint is filed with the Department of Professional Regulation the actions of the physician are judged against vague community standards of care which no one seems able to define. These same elusive standards of care are used by the investigatory agency contracted by HCFA to respond to complaints; in some of the cases we have filed, we wonder to what length the physician must go to violate these unknown standards of care for action to be taken. We have included a sampling of the cases we have received and would not be comfortable accepting the treatment of these patients as acceptable standards of medical care. (Appendix C)

VI. OMBUDSMAN COMMITTEE.

Quality assurance as it is self imposed by the HMO has been defined as merely a process or plan on paper that evidences what an HMO has adopted as a policy regarding dispensation of services. A recurring question is whether profit motivated organizations seek to maximize profits by providing a better product than their competitors or by cutting costs through reductions in quality of care. The rapidly rising costs in health care and insurance have created a market for coverage which emphasizes cost containment; quality may be compromised, whether intentionally or unintentionally, with devastating consequences to many patients.[5]

It has been noted by us that managed health care systems are strongly endorsed by the current administration and HHS Secretary, Dr. Sullivan. There must be adequate provision made to protect the patients in any managed care system where medical services are looked at from a cost effective point of view in order to provide profits for management and shareholders.

There is a perception among Medicare-HMO enrollees as well as others that current regulators are more interested in protecting the managed care providers than the patients.[6]

There is a serious need for immediate review of quality of care issues in Medicare-HMO enrollees which is not now addressed. Also, routine monitoring of quality of care grievances made directly to the HMO's is in our opinion inadequate to document deficiencies and abuses.

HEARING ON MEDICARE HMO PROGRAM

Concerned citizens are more effective advocates of the rights of others than some regulatory agencies. Therefore, we have proposed a bill in the Florida State Legislature to create an Ombudsman Committee consisting of volunteers from the medical and social service professions, and the general public, to review those complaints where timely intervention is needed in the form of medical diagnosis or treatment to prevent the patient form further deterioration and needless suffering.

We also feel this Ombudsman Committee should monitor on a random basis those complaints made directly to the HMO regarding quality of care. Too often, these are categorized as "patient contacts" rather than complaints. Only by sampling these calls and following through with the patient to see what was done to address his grievance will we ensure true quality care.

HEARING ON MEDICARE HMO PROGRAM

REFERENCES

1. Notice of Revised Draft of Proposed Amendments to Chapter 10D-100, F.A.C., State of Florida Department of Health and Rehabilitative Services, Sept. 15, 1991.

2. Sounding Board: Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans. New Eng. J. Med. 317:1729-1731, 1987

3. See Appendix A.

4. See Appendix B.

5. A Review of Health Care Services, Part IV of Chapter 641, Florida Statutes. By Staff of The Senate Committee on Health and Rehabilitative Services, Subcommittee on Health Care, January 1991.

6. Schulte, Fred: "Audit Says HMO Abuses Ongoing." Ft. Lauderdale Sun Sentinel, September 11, 1991. P. 1A, 10A.

Coral Springs
Medical Center

3000 Coral Hills Drive, Coral Springs, FL 33065 • (305) 344-3000
Jason H. Moore /Administrator

MEMORANDUM

TO: Barbara Van Strander, Vice President
HMO Patient Advocate Committee

FROM: Rosalyn Simon, LCSW,
Director, Social Services, Coral Springs Medical Center

SUBJECT: Proposed Ombudsman Council for South Florida

DATE: October 1, 1991

The attached statement presented before the Broward County Legislative Delegation on September 26, 1991 elicits many of the reasons why we endorse the creation of an Ombudsman Council for South Florida. We believe that this community based third party organization is necessary in order to monitor the complaints and review the quality of care of Medicare enrolled HMO patients.

We are also eager to endorse the legislation proposed by the HMO Patient Advocate Committee as follows:

F.S. 641.309 (1) (a)
F.S. 641.511 (3) (c) (d)

BROWARD COUNTY
LEGISLATIVE DELEGATION

THREE-MINUTE PRESENTATION

HEALTH CARE ISSUES
PUBLIC HEARING

DATE: September 26, 1991 **TIME:** 4:00 - 6:00 P.M. **PLACE:** Governmental Center

SPEAKER: Barbara Van Strander, Vice President of HMO Patient Advocate Committee

REPRESENTING: Social Service Department, Coral Springs Medical Center

ADDRESS: 3000 Coral Hills Drive

CITY, STATE, ZIP: Coral Springs, Florida 33065

TELEPHONE #: 344-3190

SUBJECT: Quality Care for HMO Patients

BACKGROUND: A 5 month quality assurance study, "Effectiveness of Discharge Planning for HMO patients Medicare and Medicaid related", has been carried out by the Social Service Department of Coral Springs Medical Center. Findings show:

1. 95% of Medicare patients with fractured hips go to in-patient rehabilitation units
2. 100% of HMO patients with fractured hips go to nursing homes
3. Medicare patients receive more home health care than HMO patients.
4. Patients hesitate to complain about services from HMOs.

PLAN/OBJECTIVE: To work with the HMO Ombudsman to advocate for equality of discharge services for HMO patients.

DELEGATION ACTION REQUESTED: We are requesting that the Broward County Legislative Delegation pass State laws requiring HMOs to provide the same quality of home care and rehabilitation services to their patients that Medicare patients receive.

APPENDIX B.

Broward General Medical Center

1600 S. Andrews Avenue, Ft. Lauderdale, FL 33316 • (305) 355-4400
Wil Trower/Administrator

To: HMO Patient Advocate Committee

From: Christine Spratt, Director Social Service

Date: September 25, 1991

RE: Proposal For Ombudsman Council for South Florida

There is a definite need for the establishment of an independent third party entity to monitor complaints and review appropiateness of care and services being rendered to Medicare/ Medicaid enrollees in the HMO system, specifically:

(1). Inadequate Discharge Planning- as regards to services a patient may or may not receive upon discharge such as extremely limited home health care; denial of appropriate skilled rehabilitation or skilled nursing facility placement. HMO patients frequently receive less services than they would be entitled and eligible for under Medicare.

(2). Patient/family awareness- when patients or families complain about the care and/or services received, especially the chronically ill patient, many wind up disenrolling from HMO in order to get the needed degree of medical care and services. Thus the HMO effectively eliminates from its rolls the client that will cost them more in medical services.

We endorse the creation of an Ombudsman Committee as an independent community - based entity to monitor quality of care by the HMO's.

We also endorse the legislation proposed by the HMO Patient Advocate Committee to amend:

F.S. 641.309 (1) (a)
F.S. 641.511 (3) (c) (d)

APPENDIX C.

HMO PATIENT ADVOCATE COMMITTEE

STATEMENT OF BARBARA VAN STRANDER, VICE PRESIDENT.

In the course of my involvement with the HMO Patient Advocate Committee, I have received complaints from patients or their families regarding inadequate medical care by their HMO provider.

Many of these complaints have been filed with the appropriate state and federal regulatory agencies for investigation. Some patients feel that to file an official complaint will jeopardize future care by their physician and the HMO, and have given us permission to tell their story without using their names.

Since the begining of the year, I have received more than 40 complaints, most of which detail the lack of accessibility to the primary care physician, the delay or denial of appropriate diagnosis and treatment, and all of which relate a lack of compassion and respect for the dignity of the patient. We offer these case histories in an effort to impress upon you the need for change in regulating HMO care of the elderly.

CASE 1. A 70 year old woman who was hit by a car while crossing the street, sustaining compound fracture of the right leg, severe bruises of the right shoulder, arm and side. Taken to the nearest hospital by paramedics and waited for 7 hours for the HMO physician to treat her. At 10 p.m. that evening her leg was set in a cast from groin to toes and HMO doctor said they would transfer her to an HMO hospital, which occurred at 3 a.m. Five hours later, at 8 a.m. she was discharged from the HMO hospital, taken to her subsidized housing apartment and left alone on the bed. No home health care or immediate followup was ordered. She was immobilized by the cast, and could not even use the bathroom by herself. Eventually surgery was done x 2, although this was delayed by the patient because the HMO never explained to her that she would be cared for after surgery and she was afraid she would be discharged home again in a helpless condition after surgery. She was left with a permanent deformity of the right leg which is painful and greatly limits her ability to walk.

CASE 2. A 76 year old white female with 8 to 10 week history of chest pain, went to the Emergency Room where CT scan showed possible stroke. Emergency Room doctor wanted to admit her but HMO refused authorization and sent her home. Patient continued to suffer chest pain and mental status changes; the HMO doctor diagnosed angina from an EKG. The family pressed for a cardiology consultation, as patient was taking up to seven nitroglycerin tablets a night for chest pain.

This appeal took four months. When a cardiologist finally saw the patient, he recommended emergency admission for cardiac catheterization, having diagnosed multiple heart attacks. The HMO again refused to authorize admission, and the cardiologist admitted her anyway. Several days later emergency five graft bypass procedure was done. This patient was in a debilitated condition due to the delay in diagnosis and treatment of her condition; further problems developed because of premature discharge from the nursing home after surgery. Patient had further problems, with stroke and seizures, and again family went to great lengths to have patient seen by a neurologist. He correctly diagnosed the condition and prescribed proper medication.

CASE 3. An 82 year old female who called the HMO in great pain and unable to walk. Patient was admitted to the hospital; discharged after ten days disoriented and with a fever, and with open infected wounds on her buttocks, spinal pain leaving her incapable of walking, or even getting to the bathroom. Followup care documented by the daughter was grossly inadequate. The family had to hire help as no home health care was allowed by the HMO. Outpatient care was minimal, and approximately six weeks later the patient had further deteriorated, and was in extreme pain with fever, and the HMO doctor still refused to readmit her to the hospital. Patient was taken to the emergency room of another hospital, and was admitted with meningitis, sepsis, pneumonia, and kidney infection. She died ten days later.

CASE 4. An 89 year old female with Alzheimer's, residing in a retirement home, able to walk by herself on admission to this facility. Husband noted bedsores on coccyx and lower buttock; took her to HMO doctor who prescribed oral antibiotics and local wound care, knowing there was no skilled medical help at the patient's living facility. Three weeks later a Medicare nurse was seeing other patients in this facility, and the husband asked her to look at the patient's bedsores; she said they had progressed to decubitus ulcers and in her opinion were probably gangrenous, and she called HRS. Husband called the HMO who gave him an appointment for five days later. HMO doctor confirmed diagnosis of decubitus ulcers and referred patient for surgery. General surgery consult was done three days later; at this time lesions were large and foul smelling according to husband. Surgeon examined patient and said two procedures with skin grafting would be necessary and referred patient back to HMO doctor for plastic surgery consult. HMO held up this referral for another 12 days. By the time the patient saw the plastic surgeon and was admitted to the

hospital, she was so debilitated surgery could not be done for another week. Patient was discharged before the wounds were adequately healed, without home health care. Two weeks later patient again had fever and was readmitted to the hospital for two weeks of wound care. Patient never regained ability to walk; developed severe contractures of both legs and required nursing home care which the HMO refused to pay for.

CASE 5. 61 year old man on dialysis with several complaints; one of which was the refusal of the HMO to provide a prescribed drug, routinely used for dialysis patients, because of cost. Patient called Senior Citizen Law Project of Broward County who intervened, and patient then received the necessary medication.

CASE 6. Patient with a history of triple bypass went to HMO doctor with symptoms similar to the angina he had experienced prior to bypass surgery. HMO doctor refused to order appropriate tests and recommended the patient leave the HMO if he wanted further testing and treatment. Patient did so, and three months later underwent another bypass procedure. Patient is now fully rehabilitated and an avid tennis player.

CASE 7. An 82 year old retired physician, suffered a mute aphasic episode with recurrence the next day. He called his HMO facility and was sent to the hospital for examination. He was given what he terms a cursory neurologic examination by the neurologist the day after admission. Neurologist diagnosed TIA and put the patient on anticoagulation therapy, with Coumadin, and discharged the patient three days later. Patient requested an MRI for definitive diagnosis and was told by the physician-owner of his HMO clinic that this was not available. The neurologist ignored repeated attempts by the family and the patient to see him again.

The patient felt that because of the nature of his symptoms the diagnosis of TIA may have been premature. He disenrolled from the HMO, sought a second opinion. The second opinion neurologist performed the MRI and diagnosed subdural hemorrhage. Coumadin was immediately stopped.

CASE 8. A 59 year old female on medical disability enrolled with an HMO. Her problem was severe incontinence, leaving her unable to lead a normal life and pretty much confined to her home. Surgery for bladder suspension was recommended by the urologist and gynecologist; however HMO kept saying she needed more tests and examinations.

Patient had anginal attack which she attributed to the delay in definitive treatment for almost a year.

I accompanied the patient to her clinic to ask her doctor why she was not authorizing the surgery. The doctor signed off the case as a result of my questions. I then spoke by telephone with the administrator of the clinic, who set up new appointments for the patient and patient had her surgery two weeks later with excellent results.

CASE 9. An 89 year old woman with Alzheimer's, whose daughter repeatedly called her HMO physician because of febrile illness and was told he was not available. Finally called 911 when fever went over 104. Went to HMO hospital; patient required special diet and someone to feed her; food was often left by the bedside, no fluids were administered, no I.V.'s, no consultations with any specialists, and patient was often found by the family to be sleeping all day due to medications. She was also in restraints. When doctor ordered discharge daughter was notified to she had half an hour to pick up her mother. Daughter was willing to hire nurses for home care if HMO would provide medical equipment. Administrator for the HMO clinic was generally unavailable, and ultimately the only thing provided was a bedside commode. No home care was provided by HMO, no oxygen; patient continued at home to have a fever of 102, difficulty breathing, too weak to walk. HMO clinic said bring her in for examination; family had no wheelchair and daughter had to carry her mother to the car and had difficulty obtaining a wheelchair once she arrived at the clinic. Examining physician said she could not hear chest sounds due to patient's loud moaning. Dr. prescribed Tylenol and fluids, and said come back in two weeks.

Next two days patient was vomiting, with fever, difficulty breathing. Called 911 who started an I.V. and oxygen, and told daughter the patient was in kidney failure and very dehydrated. Patient admitted to ICU at HMO hospital; daughter had obtained from me the name of the Regional Director of HMO at HCFA, and had called him with her complaints; and her mother received much better care during this second hospitalization. Patient ultimately discharged to nursing home with fever, on tube feedings, catheterized, with I.V.'s; went into hospice program after several days and expired.

Mr. WAXMAN. Thank you very much. Mr. Amsden.
Mr. AMSDEN. Thank you.

STATEMENT OF PERRY AMSDEN

Mr. AMSDEN. Good morning. My name is Perry Amsden. I am from Brewer, Maine, and I am a member of the AARP National Legislative Council.

I am pleased to have the opportunity to discuss the need for an effective quality assurance system in Medicare risk-contract HMO's and to outline several issues which are of particular concern to beneficiaries.

AARP supports the development of HMO's as an option for Medicare beneficiaries. When administered properly, HMO's can effectively oversee total patient care and discourage unnecessary hospitalization. Unfortunately, experience has shown us that financial incentives can also create the temptation for HMO's to skimp on care.

Unless quality standards are enforced, beneficiaries enrolled in HMO's cannot be confident that they receive the best care.

My testimony examines four specific issues pertaining to quality assurance in HMO's: One, the current system of quality review; two, the shortcomings in this system; three, the serious problems beneficiaries face when strong quality assurance is lacking; and four, improvements that need to be made.

Medicare HMO's are required to undergo both internal and external quality review. Let me briefly explain this process. The evaluation of an HMO's internal quality assurance plan, which is required of HCFA, is purely a paper determination. The actual effectiveness of a quality assurance plan is not assessed by either HCFA or a PRO.

External review of HMO quality is conducted by PRO's. Simply put, in this process a sample of HMO medical records is reviewed to identify potential quality problems. If the PRO determines that a pattern of quality problems exist, the HMO must develop a corrective action plan. PRO's are then supposed to monitor the implementation of this plan.

Unfortunately, neither the internal nor external quality review process works as well in practice as it is intended. Deficiencies in the system have caused a serious breakdown in quality assurance. As a result, Medicare beneficiaries enrolled in HMO's are increasingly vulnerable to poor quality care.

An especially poignant example of how this lack of strong quality enforcement can endanger Medicare beneficiaries is the case of Dorothy Barrett from St. Petersburg, Fla., referred to by Congressman Smith earlier this morning. AARP, too, has talked with Ms. Barrett about her case. We have included a detailed account of her story in our written testimony, and I shall not recount her experience.

Ms. Barrett was enrolled in the Humana Gold Plus HMO. She left the HMO after doctors repeatedly refused to send her to a specialist or to order necessary tests, despite the fact that she had been experiencing severe rectal bleeding for several months. When Ms. Barrett sought care outside of the HMO, it was discovered that

she had been suffering from colon cancer. She underwent surgery and today is slowly regaining her health.

We do believe, however, that incentives to cut costs and a serious lack of quality assurance in the Florida HMO could have cost Dorothy Barrett her life. Yet, even after HCFA was notified of the incident, it took nearly a year before her case was considered by a PRO. She has not been notified about what corrective action, if any, was taken or what improvements were made to protect those beneficiaries who remained in the HMO.

This case, as well as the GAO report, confirm what AARP has suspected for some time. There is not effective internal or external quality assurance for risk-contract HMO's. We believe that there are three major problems underlying this failure: One, there is no requirement that international Quality Assurance Plans be subjected to a PRO review; two, there is a serious lack of centralized data necessary to conduct external reviews; three, there is insufficient scope and authority for HCFA to take action when necessary and failure to enforce requirements that do exist.

To correct these problems, AARP believes that there are a number of steps that should be taken: One, HMO's should be required to submit internal quality assurance plans for PRO review; two, HMO's should also be required to maintain centralized data on all enrollees; three, HCFA should incorporate PRO findings into its HMO contracting process; four, there should be stricter requirements for PRO action when quality problems reach a critical level; and five, HCFA should have authority to impose sanctions other than contract cancellation.

A more detailed discussion of these recommendations is included in our written testimony.

AARP believes that these improvements in both the internal and external review systems must be made so Medicare beneficiaries enrolled in risk-contract HMO's can be assured of receiving high-quality care.

Finally, Mr. Chairman, AARP believes problems with the quality assurance system in risk-contract HMO's have implications far beyond the Medicare program. HCFA has advocated the expansion of managed care as an option for reforming the health care system. Yet, unless the serious problems that persist in the Medicare HMO program can be eliminated, the possibility that quality care would consistently be delivered under a more expanded managed care system is doubtful.

AARP stands ready to work with you, Mr. Chairman, and the members of this committee in improving the system so that all Medicare beneficiaries can be assured of receiving the best possible health.

[Testimony resumes on p. 108.]

[The prepared statement of Mr. Amsden follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

PERRY AMSDEN

National Legislative Council of AARP

Good morning. My name is Perry Amsden. I am from Brewer, Maine and I am a member of the American Association of Retired Persons' National Legislative Council. I am pleased to have the opportunity to discuss the need for an effective quality assurance system in Medicare risk contract Health Maintenance Organizations (HMOs) and to outline for the Committee several issues which are of particular concern to beneficiaries.

AARP supports the development of Health Maintenance Organizations as an option for Medicare beneficiaries. When administered properly, HMOs can effectively oversee total patient care, manage the use of services, and discourage unnecessary hospitalization. Unfortunately, experience has amply demonstrated that the financial incentives for HMOs can create a temptation for providers to skimp on necessary care. Unless quality of care standards are enforced, over one million Medicare beneficiaries, whose choice of care and providers is restricted by their enrollment in an HMO, cannot be confident that they are receiving the best care or be assured that when a problem is identified, corrective action will be taken. To assure these beneficiaries of the highest quality of care, serious deficiencies in the current system must be addressed. This becomes all the more important as managed care is considered in a larger context.

My testimony will examine four specific issues pertaining to quality assurance in HMOs: first, the structure of the current system of quality review and enforcement; second, the shortcomings in this system; third, the serious problems beneficiaries face when there is a lack of strong quality assurance in HMOs; and fourth, improvements that need to be made to strengthen quality assurance within HMOs.

CURRENT REQUIREMENTS FOR QUALITY REVIEW

The Consolidated Omnibus Budget Reconciliation Act of 1985 expanded the Medicare peer review program to include risk contract HMOs. To participate in Medicare, HMOs are required, by law, to undergo both internal and external quality review.

Internal

The internal review requirement is satisfied if the Health Care Financing Administration (HCFA) determines that the HMO has a written quality assurance plan (QAP) that meets certain standards. The QAP must (1) stress health outcomes; (2) provide review by physicians and other health professionals of the HMO's delivery of services; (3) use systematic collection of data on treatment results, provide feedback on this to practitioners, and institute needed change; and (4) include written procedures for taking needed remedial action.

HCFA's determination of the adequacy of an HMO's internal quality assurance plan is based purely on a structural review -- a paper determination that the QAP contains the required statutory and regulatory elements. HCFA does not assess the QAP in practice to determine whether or not it is effective. Peer Review Organizations (PROs) are not required by law to review the effectiveness of an HMO's internal QAP. PRO review of an internal quality assurance plan is optional on the part of the HMO.

External

PROs focus primarily on external review of HMO quality. By law, the Secretary of Health and Human Services contracts with PROs to review the medical outcome, quality and appropriateness of services provided to Medicare beneficiaries in risk-contract HMOs.

To accomplish this, PROs follow a review process similar to the one used with fee-for-service hospitals. PROs review a sample of HMO medical records from four categories related to hospital services. These include medical records of: 1) enrollees admitted to an inpatient hospital; 2) enrollees hospitalized with one or more of thirteen specified conditions; 3) non-trauma deaths; and, 4) patients who were readmitted to the hospital within 30 days of discharge.

The size of the sample considered by the PRO depends upon the HMO's review category. Initially, an HMO is put into one of two review categories -- limited or basic -- depending upon the condition of its quality assurance plan. Those HMOs which voluntarily submitted their QAP to the PRO for review and have been judged by the PRO to have an effective plan in practice would receive limited reviews. Those HMOs which either did not submit a QAP to internal review or whose QAPs were found inadequate to identify and correct quality problems are subjected to basic level review. Basic level reviews require a larger sample size of medical records then are required under limited reviews.

A third category, an intensified review, occurs only if the PRO finds that at least five percent of an HMO's cases in a three-month period show inadequate treatment. Case samples in an intensified review are significantly larger than the other two categories (i.e. 100 percent sample of non-trauma death cases are sampled as opposed to 5 percent in a limited review) and the review will continue for a longer time period.

The records for any of the three levels of review are screened by a medical professional who identifies any potential quality problems. Because of the unique nature of HMOs, the review also considers the "episode of care," examining whether the care was

provided in one setting or hospital admission or in several settings and admissions. Next, a physician reviews those records viewed as problems. If the doctor agrees that a problem exists, the case is brought to the attention of the HMO which is then given an opportunity to provide additional information. If the PRO determines that a pattern of quality problems exists, the HMO is required by law to develop a corrective action plan. As part of their contractual arrangement with HCFA, PROs should monitor an HMO's compliance in carrying out the corrective action plan.

In the case of a beneficiary who brings a quality complaint to the attention of the PRO, the system of review is similar. However, once the PRO has determined that a quality problem exists, it is required, by law, to inform the beneficiary that action has been taken. The PRO does not have to specify the specific course of action taken and is prohibited from disclosing the name of any physician involved.

SHORTCOMINGS IN THE CURRENT QUALITY ASSURANCE SYSTEM

Unfortunately, the quality review process for HMOs does not always work as well in practice as is intended. Persistent deficiencies in the system have caused a serious breakdown in quality assurance. As a result, Medicare beneficiaries enrolled in HMOs are becoming increasingly vulnerable to poor quality care.

An especially poignant example of how this lack of strong quality enforcement can endanger Medicare beneficiaries is the case of Dorothy Barrett from St. Petersburg, Florida. Mrs. Barrett told AARP that, in 1989, she was enrolled in the Humana Gold Plus HMO. Early in the year, when she discovered rectal bleeding, she sought care through the HMO. She was told that the bleeding was simply due to hemorrhoids, but no physical examination was ever performed. Months later, the 82-year old woman returned to the HMO when the bleeding persisted and requested that she be referred to a specialist. According to Mrs. Barrett, the HMO refused to call in a specialist or order a colonoscopy. Instead, she was diagnosed as suffering from an irritable bowel.

Four months later, when the bleeding increased dramatically, Mrs. Barrett again returned to the HMO for care but was once again refused a referral to a specialist and no colonoscopy was performed. She then quit the HMO and sought care from a gastroenterologist who immediately diagnosed her symptoms as colon cancer. She underwent surgery to remove the cancer and is slowly regaining her health.

The problems Mrs. Barrett faced were further exacerbated when she left the HMO. She received no assistance in transferring her medical records or in properly disenrolling from the HMO to ensure that her Medicare coverage would not be disrupted.

Incentives to cut costs and a serious lack of quality assurance in the Florida HMO could have cost Dorothy Barrett her life, yet it was not until she contacted her member of Congress, who in turn contacted the Health Care Financing Administration's regional office in Atlanta that her case was even examined. After HCFA was notified of the incident, it took nearly a year before her case was considered by a Peer Review Organization. To date, Dorothy Barrett has still not been notified about what corrective action, if any, was taken or what specific improvements were made to ensure quality care for those Medicare beneficiaries who remained in the Florida HMO.

The case of Mrs. Barrett and others like her as well as the GAO study "MEDICARE: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs," published last spring, confirms what AARP has suspected for some time: there is not effective internal or external quality assurance for Medicare risk contract HMOs.

AARP believes that there are three major problems underlying the failure of quality review for Medicare beneficiaries in HMOs:

1. <u>There is no requirement that internal QAPs be subjected to a PRO review or to more than a paper review by HCFA</u>. The GAO has emphasized the importance of an effective internal quality assurance plan as a "first line of defense" for Medicare beneficiaries, yet there is no mandatory PRO review

of the effectiveness of the QAP. Of the barely 25 percent of risk-contract HMOs that have subjected themselves to voluntary review by the PROs, a majority could not demonstrate the capacity to identify and correct quality problems. A significant number of this group did not even meet the paper requirements for a QAP.

2. There is a serious lack of centralized data necessary to conduct external reviews. To date, PRO review of HMO services has been limited to examining records identified through "no-pay" bills obtained from fiscal intermediaries. Although HMOs and hospitals are required by HCFA to submit these bills to PROs, there is no penalty to enforce this requirement beyond contract termination. Therefore, many HMOs and hospitals still do not submit all of their "no-pay" bills to the intermediaries, which hinders PRO review.

3. There is insufficient authority for HCFA, the PROs or HMOs to take action when necessary, as well as failure to enforce those requirements that do exist. PROs have no contractual requirement to ensure that deficient internal QAPs are corrected. HCFA has no sanction authority to require HMOs to comply with existing data submission requirements -- such as the "no-pay" bills -- short of contract termination. In cases where internal and external reviews have been completed, HCFA has not incorporated the results into its

oversight of the HMOs or followed up on problems uncovered during PRO review, leaving beneficiaries, like Mrs. Barrett, vulnerable to seriously inadequate care.

AARP RECOMMENDATIONS

AARP believes that there are a number of steps that should be taken to improve both the internal and external quality review for Medicare risk contract HMOs.

* HMO internal quality assurance plans should be subjected to more than a paper review. HCFA should contractually require that HMOs submit internal quality assurance plans for PRO review. Any deficiencies identified in these plans should be corrected and HCFA should be required to monitor the on-going effectiveness of the plans.

* HMOs should be required to maintain centralized data on enrollees. This is not an unreasonable prerequisite for an organization whose mission and contractual responsibility is to manage and coordinate care.

* HCFA should incorporate PRO findings into its HMO contracting process. The current policy of not requiring HMO-specific data conveys to the world that the agency does

not know whether individual HMOs are providing high quality care to beneficiaries; and, moreover, does not want to know.

* AARP recommends stricter requirements for PRO action when quality problems reach a critical level. We are disturbed at the GAO report's finding that even when the number of quality problems within an HMO reached levels which require intensified reviews, at least one PRO out of the six reviewed failed to place an HMO on an intensified review.

* HCFA should also be granted authority to impose sanctions other than contract cancellation. We are seeing evidence of a "too big to fail" mentality applied to Medicare risk contract HMOs. The ability to suspend enrollment and impose financial penalties is necessary to correct long-standing and difficult problems with marketing practices, inadequacy of provider networks, and failure to provide PROs with the data necessary for external quality reviews. These intermediate steps would have the advantage of motivating HMOs to correct quality lapses while not subjecting beneficiaries to the disruption of contract termination.

REVISION OF PRO EXTERNAL REVIEW PROCEDURES

Over the past year, there have been discussions about revising the current external review procedures and methodologies. We

understand the desire to tailor a review system that is more appropriate to the managed care environment, and to focus interventions on correction of problems. However, we remain very concerned that many problems will go undetected if the sampling methodology used to trigger HMO review is flawed. Therefore, it is critical that any new sampling methodology be able to detect quality problems. AARP has outlined several major areas that need to be addressed in testimony we presented earlier this year.

CONCLUSION

AARP believes that all individuals have a right to high quality health care. To this end, we believe that the time is long overdue to correct the inadequacies of the quality review system that currently exist in Medicare risk contract HMOs. We can no longer tolerate a system which is unable to guarantee that beneficiaries will receive the best care possible.

AARP does not believe that continued reliance on current internal and external quality review practices is adequate. We have consistently endorsed the Congressional judgment that strong external review is necessary and that enforcement is essential in both processes. Therefore, we believe that the important task now is to implement improvements in both the internal and external review systems so that Medicare beneficiaries enrolled

in risk contract HMOs can be assured of receiving high quality care.

AARP believes these improvements will also have implications beyond the Medicare HMO program. HCFA has consistently supported the expansion of managed care as an option for reforming the health care system. Yet, unless the serious quality assurance problems that persist in the Medicare HMO program can be eliminated, the possibility that the highest quality of care can be guaranteed under a more expansive managed care system is doubtful.

AARP is encouraged that members of the HMO industry and the PROs, as well as members of Congress, have been actively seeking a consensus on a long-range reform of the quality oversight program. We hope that the outcome of these discussions will lead to the necessary improvements in the current quality assurance system.

AARP stands ready to work with you, Mr. Chairman, and the members of this Committee in improving the system so that all Medicare beneficiaries can be assured of receiving the best possible health care.

KS3-HMO-11/7/91

Mr. WAXMAN. I want to thank the three of you. You have given us excellent testimony, and I appreciate your being here.

Let me ask whether you believe that the problems you have identified can be addressed through more vigorous and timely monitoring and enforcement efforts, or whether amendments to current Medicare law are required?

Ms. HARPER. In the area of marketing, if HCFA goes through with its plans in terms of using intermediate sanctions to enforce better compliance in the marketing area, I believe that would be a major step forward.

In the area of the appeals process, particularly in terms of authorizing an expedited review of quality-of-care claims, I think that would require legislation.

Ms. TORGAN. I concur with what Ms. Harper said. However, I think the key here is monitoring, and I think that is what is really missing.

We found that with our own committee, when we got reports from the Sun Sentinel, we had so many calls from citizens that were not receiving quality care; and it was only when we stepped in and advocated for those people, and sometimes even threatened to go to the newspapers, that we were able to get the proper care for these patients.

I don't believe that that is the American way. I think that putting profits before—over the pain and suffering of others is just not the right way, and there does have to be much more oversight.

I believe that ombudsman committees can perform a very necessary service. Concerned citizens go much beyond, than sometimes agencies that are there to regulate these kinds of problems.

Mr. WAXMAN. I think that is right.

Mr. AMSDEN. I was a little distressed at Dr. Wilensky's comment about the fact that beneficiaries can make decisions with their feet. I don't think that is an appropriate answer to the concern about quality assurance, because while some may leave, those that remain are at risk and at serious risk.

Second, I would like to say that it is obvious that HCFA has regulatory authority at the present time. My concern is the same as the one you expressed this morning. Why does it take 3½ years to issue rules?

Third, I would like to say that I think that many of these issues could be taken care of if HCFA would simply go ahead and enforce. There may be some technical issues that need to be addressed in terms of our own recommendations that I enumerated in my commentary.

Mr. WAXMAN. Ms. Harper and Ms. Torgan, you commented on problems with timely referral of HMO enrollees for hospital care and hospitalization. Have you been able to determine whether the amount of care and financial risk is related to these referral problems?

Ms. HARPER. I believe when I have a situation where the person who is authorized for paying for care is the decisionmaker concerning access to services, you clearly create a conflict of interest that is significant, and I believe that is an important issue.

One of our recommendations is the need to limit the financial risk that is placed on contracting providers.

Ms. TORGAN. In a lot of the reading that I have done, and my committee has done, it has been established that those HMO's that are not for profit and that do not rely on a capitation system—because we find that this is where all the abuse is coming from—when there are salaried physicians those HMO's are working effectively and do not sacrifice the quality of care given to the HMO Medicare enrollees.

Mr. WAXMAN. Could any of you comment on your experience at trying to bring complaints or problems to the attention of HCFA first?

Ms. HARPER. I must say that during the 7 years I have been with MAP, we began complaining about HMO issues beginning in 1986-87. We have had ongoing talks with the regional office of HCFA concerning problem areas in marketing, quality care, the appeals process.

I have gotten the impression that the regional office has felt inadequate or unable to really exercise enforcements. Problem areas are continually identified in monitoring reports and yet problems continue to arise 4 or 5 years later.

Mr. WAXMAN. Why do you think that is the case if the regional offices of HCFA are aware of these problems?

Ms. HARPER. I feel that intermediate sanctions, that regulatory authority for—HCFA has had a position that because they don't have immediate sanction authority, all they can do to a HMO is terminate their contract, and HCFA is not prepared to do that.

Mr. WAXMAN. Failure to issue regulations hampered——

Ms. HARPER. Seriously hampered the regional office's ability to enforce assertively.

Mr. WAXMAN. Do any of the others of you want to comment on your experience in bringing problems to the attention of HCFA?

Ms. TORGAN. We haven't had many. We have found that, working on a local level, we have been able to resolve most of the complaints.

Mr. AMSDEN. AARP has had a number of complaints written in, and I am not personally aware of where they were directed. I will ask staff to get back to you on that point.

Mr. WAXMAN. If you have anything else you want to add to that, we would be pleased to receive it for the record.

Let me thank the three of you very much.

Our last panel includes representatives of HMO associations whose members include Medicare risk-contractors. Aubrey Davis, president emeritus of Group Health Cooperative of Puget Sound of Seattle, Wash., is testifying today on behalf of the Group Health Association of America. Dr. James Ehlen is chairman and chief executive officer of MEDICA, an HMO in Minneapolis, here representing the American Managed Care and Review Association.

Gentlemen, welcome to our hearing today. Thank you for your participation. Your prepared statements will be in the record in full. We would like to ask you to limit the oral presentation to no more than 5 minutes.

Mr. Davis.

STATEMENTS OF AUBREY DAVIS, PRESIDENT EMERITUS, GROUP HEALTH COOPERATIVE OF PUGET SOUND, ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA, ACCOMPANIED BY LESLIE ROSE, LEGISLATIVE DIRECTOR; AND K. JAMES EHLEN, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, MEDICA, ON BEHALF OF AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Ms. DAVIS. Good morning, Mr. Chairman and members of the subcommittee. My name is Aubrey Davis, and I am president emeritus of Group Health Cooperative of Puget Sound, a nonprofit staff model HMO based in Seattle, Wash. Group Health has been in business since 1947, and today we serve 472,000 persons. We are the Nation's largest consumer-governed health care organization.

I am here today on behalf of the Group Health Association of America, Inc. GHAA is the Nation's oldest and largest trade association for the health maintenance organization industry. GHAA's members enroll 75 percent of the 36.5 million people enrolled in HMO's.

Today's TEFRA Medicare Risk-Contract Program was established in 1982. There are currently 93 HMO's that contract under this option, which enroll nearly 1.4 million Medicare beneficiaries. Nearly 43,000 Medicare beneficiaries in the State of Washington are enrolled at our plan under this option.

HMO's, either federally qualified or certified as a Competitive Medical Plan to contract under Medicare, must meet a long list of requirements dealing with benefit offerings, access and availability of services, quality of care, premium setting, limits on copayments, financial solvency, marketing, and physician incentive arrangements. The standards to which these HMO's are held are higher than for any other segment of the health care marketplace. And that is fine. GHAA supports strong HCFA oversight and compliance activity.

The fact that the HMO industry as a whole performs well and, importantly, that member satisfaction is very high, is sometimes lost. However, occasionally press attention, or a report, focuses on a small number of anecdotes or isolated problems. This is used to frighten Medicare beneficiaries. And, of course, there is no discussion about what Medicare beneficiaries face in the fee-for-service sector where care is fragmented and largely unmonitored.

The advantages of the Medicare TEFRA program for Medicare beneficiaries are many. This program successfully addresses the major concerns Congress has been focusing on recently in health care reform discussion—access to affordable, quality, comprehensive health care and protection from catastrophic health care costs.

Payment of a fixed monthly premium—the average monthly premium for October 1991 is $42.06—buys out an enrollee's Medicare deductibles and coinsurance. The enrollee receives all the required basic Medicare services plus many supplemental benefits, including preventive services such as immunizations, physicals, and screening tests, plus eye care, ear exams, foot care, and health education. One-third of the TEFRA risk-contractors also provide an outpatient prescription drug benefit.

No balance billing is permitted. There are no claim forms to fill out. Out-of-pocket costs for all these services is limited; for example, an average office visit copayment is in the $7 to $9 range. No health status screening, exclusions, or waiting periods for preexisting conditions is permitted.

HMO's offer Medicare beneficiaries considerable advantages. But enrollment under TEFRA contracts is still limited. Of great concern is that a number of well-established HMO's with long experience with the Medicare program are encountering difficulties because of inadequate payment. Many now are seriously considering shifting to other options, such as cost contracts.

While we understand discussion today has focused on program compliance in the areas of marketing and quality, the issue of payment reform is also vital. It is a matter of survival to many of the HMO's which have participated in this program the longest. If this issue is not resolved, you will have very few HMO's left in the program.

My own HMO is a case in point. We are seriously evaluating whether we can remain in the program. Our increase in AAPCC payment rates was one of the lowest in the country. This also occurred in other areas such as Portland, Oreg., and Minneapolis, where HMO enrollment of Medicare beneficiaries is the highest.

In several categories, such as end-stage renal disease and institutionalized services, the government payment is about half of the cost of services. We lost $2 million on ESRD patients alone last year, another $2 million on institutional members because of underpayment. We predicted a loss of $6 million in 1992, largely because of these two factors.

Recent studies comparing the quality of care in HMO's to that of the fee-for-service sector continue to confirm that HMO's provide care that at least equals and often surpasses the fee-for-service in quality. A summary of these studies is attached to our written statement.

Enrollees in HMO's benefit from greater access and use of preventive services and early detection screening examinations and tests, and several studies have concluded that early identification and treatment of health problems accounts in part for the lower hospitalization rates of many HMO's.

HMO's have also been shown to be effective in managing patients with chronic illnesses. A recent study by Rand found that HMO enrollees had better overall quality of care than those in the fee-for-service sector.

Despite consistently positive findings regarding the overall quality of care in HMO's, HMO's are subject to greater scrutiny than the fee-for-service sector. For HMO's with Medicare TEFRA risk-contracts, PRO's review care provided in both hospital and ambulatory settings.

GHAA supports strong quality oversight processes and recognizes the potential benefits to be derived. We believe that external oversight of the accessibility and quality of care provides strong incentives to HMO's to continually improve their performance, and provides necessary protection to beneficiaries.

We encourage the subcommittee to work with us to help modify the current review system so that it is more appropriate to the

HMO delivery system, including a more workable method of review of an HMO's own internal quality assurance program.

Also, incidentally, there is a need for an equivalent oversight process in the fee-for-service sector.

HMO's want to have as members people who have carefully evaluated their health care choices. This means marketing efforts must help inform people. As part of an effort to ensure that HMO marketing practices are appropriate, GHAA has sponsored special educational conferences, developed printed materials, and with the help of member plans, developed "Marketing Guidelines" that have been endorsed by the GHAA board of directors. I would like to submit for the record the GHAA "Marketing Guidelines" and our document on "Helping Older Adults Make Informed Decisions About Joining an HMO." They are attached to our statement.

Mr. Chairman, our statement today has covered a variety of issues of importance to this subcommittee. We don't believe isolated incidents or problems should derail the program. The HMO's which participate in this program must meet a variety of standards. GHAA fully supports strong oversight and compliance activity to ensure that these standards are met. Unless payment reform is addressed, however, the program may not survive.

We look forward to working with you and to ensuring that this is a program we are all proud to promote.

I would be happy to answer any questions.

[Testimony resumes on p. 144.]

[The prepared statement of Mr. Davis follows:]

STATEMENT ON

THE MEDICARE TEFRA RISK CONTRACTING PROGRAM

FOR THE

GROUP HEALTH ASSOCIATION OF AMERICA, INC.

BY

AUBREY DAVIS

Good morning Mr. Chairman and members of the Subcommittee. My name is Aubrey Davis and I am President Emeritus of Group Health Cooperative of Puget Sound, a non-profit staff model HMO based in Seattle, Washington. GHCPS has been in business since 1947 and today we have 474,000 members, or one in every 7 residents in the state of Washington.

I am here today on behalf of the Group Health Association of America, Inc. (GHAA, Inc.). GHAA is the nation's oldest and largest trade association for the health maintenance organization (HMO) industry. GHAA's members enroll 75% of the 36.5 million people who are members of the country's 569 HMOs.

We are here today to talk about the state of the TEFRA Medicare Risk program. The Medicare Risk Contract Program was established in 1982 under TEFRA (P.L. 97-248) with the strong support of members of Congress, the Administration and the HMO industry. Its purpose is to provide Medicare beneficiaries the same opportunity for enrollment in HMOs as exists for the under-65 population. There are currently 93 HMOs which contract under this option and enroll nearly 1.4 million Medicare beneficiaries. My own plan has approximately 43,000 Medicare beneficiaries in this program.

As a result of payment anomalies, enrollment is now concentrated in a very few metropolitan areas and in a few HMOs. For example, 75% of all TEFRA enrollees reside in only 29 counties out of more than 750 urban counties in the nation. Over 26% of these Medicare TEFRA risk enrollees reside in the Los Angeles metropolitan area, 10% in Miami, 5% in Tampa and another 5% in San Diego. In 1990, in nine states, TEFRA enrollees accounted for more than 5% of the Medicare population -- Minnesota 22%, Oregon 14%, Nevada 8%, California 10%, Colorado 10%, Hawaii 10%, Florida 9%, Washington 8%, and New Mexico 6%.

As our population ages, more and more people now have experience with HMOs. In fact, HMO penetration is already very high in some States. As you know Mr. Chairman, in your own state of California, HMOs enroll 32% of the general population. Not every Medicare beneficiary is comfortable with the HMO concept - they are not used to the idea of a lock-in or restriction to certain providers. But, Medicare beneficiaries in some areas are comfortable with the HMO delivery system. In some areas, HMOs enroll the same or higher proportion of Medicare beneficiaries as they do under-65 individuals. This is true in Portland, Oregon, Los Angeles/San Diego, Tampa and Miami.

Normally, when someone joins with an HMO, usually through their employer, they become a member for a minimum period of a year. When TEFRA was created a special feature was included - it does not work like general HMO practice - Medicare beneficiaries may disenroll at any time.

HMOs, either federally qualified or certified as a Competitive Medical plan (CMP) to contract under Medicare, must meet a long and varied list of requirements dealing with benefit offerings, access and availability of services, quality of care, premium setting, limits on copayments, financial solvency, marketing, physician incentive arrangements and so on. The standards to which these HMOs are held are probably higher than for any other segment of the health care marketplace. And that's fine. GHAA supports HCFA oversight and compliance activities to assure these standards are met.

However, occasionally press attention, or a report, focuses on a small number of anecdotes or isolated problems. These are used to frighten Medicare beneficiaries or to cast a shadow over the Medicare TEFRA program specifically or the entire HMO industry in general. The fact that the HMO industry as a whole performs well, and importantly, that member satisfaction is very high, is lost. And of course, there is no discussion about what Medicare beneficiaries face in the fee-for-service sector where care is fragmented and largely unmonitored.

ADVANTAGES OF THE MEDICARE TEFRA PROGRAM

I'd like to talk about the advantages that the Medicare TEFRA program provides to Medicare beneficiaries. The very nature of this program addresses the major concerns Congress has been focusing on recently in health care reform discussion - access to affordable, quality, comprehensive health care and protection from catastrophic health care costs. It is also

consistent with the national private sector strategy of encouraging providers to be involved in managing care and costs and quality in health care as Congress intended under physician payment reform, as well as outcomes research and practice guidelines.

In exchange for a fixed monthly premium - the average monthly premium for October 1991 is $42.06 (or under $505 per year), an enrollee's Medicare deductibles and coinsurance are "bought out" by the premium. The beneficiary continues to pay the Part B premium. In exchange for this monthly premium, the enrollee receives all the required basic Medicare services plus - 96% of all HMOs offer supplemental benefits, including preventive services such as immunizations, physicals and screening tests, plus eye care, ear exams, foot care, health education and so on; one third of the TEFRA risk contractors also provide an outpatient prescription drug benefit.

The cost sharing for these Medicare beneficiaries is predictable and minimal and protects them from catastrophic financial costs. The monthly premiums are reasonable and the cost savings to the beneficiary are significant. The average value of savings to the beneficiary in 1990 was $475.25 per year for not having to pay an annual hospital deductible or 20% coinsurance. No balance billing is permitted. There are no claim forms to fill out. Out of pocket costs for all these services is limited; for example, an average office visit copayment is in the $7-$9 range.

Besides being protected from high out of pocket costs, and reducing financial barriers to basic Medicare services, over 80% of HMOs in this program cover supplemental services at no additional cost to the enrollee. The average value of these supplemental services is approximately $268.28 per year.

Experience and research done by Mathmatica indicates that because of favorable premiums, low coinsurance and comprehensive benefits, HMOs are particularly attractive to the low-income elderly and have a major role to play in improving their access to Medicare-covered benefits. These are Medicare beneficiaries who often have no supplemental coverage. People know they are unwell and "ought to see a doctor", but cannot afford the 20% copayment or additional out of pocket costs for physicians who do not accept assignment. Instead of getting treatment in the early stage of a disease, the patient waits until the condition is so bad they are admitted to the hospital. The result is that their health is impaired and costs for care are then higher.

HMOs also do not health screen Medicare enrollees. There are no waiting periods or exclusions permitted for pre-existing conditions.

Medicare beneficiaries in HMOs are significantly more likely than those in fee-for-service medicine to receive care that includes major components necessary for high quality health care: complete medical histories, screening examinations, and screening tests.

Findings from the National Medicare Competition Evaluation sponsored by HCFA shows that HMOs are paying attention to the medical needs of the elderly. The care received in an HMO is much more likely to be complete and coordinated. The medical records of HMO patients are significantly more likely to include record of a past medical history, drug allergies, all current medications, and alcohol and tobacco use. In addition, those receiving care in an HMO more often had screening exams, specifically breast, pelvic, rectal, neurologic, and genitourinary; and screening tests, in particular, visual, acuity, tonometry, hemoccult, and urinalysis. Mammography was twice as likely to be performed for patients in the HMO as patients receiving care under fee-for-service medicine.

The study reviewed the medical records of 800 Medicare beneficiaries receiving care in either an HMO or under fee-for-service medicine. The study was conducted at 17 locations across the country; comparisons were made for HMOs and fee-for-service patients in like geographic locations. Although the beneficiaries enrolled in HMOs were slightly younger, they had more chronic health problems at the time they joined their HMOs.

A number of HMOs contracting under TEFRA have also tailored programs especially for the elderly. Some of these HMOs and their innovative approaches were studied by the Robert Wood Johnson Foundation. For example, at Group Health Cooperative of Puget Sound:

In the early 1980's Group Health recognized the importance of planning for the aging of the population and developing innovative approaches to caring for our elderly enrollees. The "Long Term Care Committee" was established with representatives from management, medical staff, nursing and consumers to develop a long range plan for the delivery of care to seniors with an emphasis on improving health care and reducing costs.

Since then a number of innovative programs and services have been implemented that focus on health promotion and preventive care as well as acute care and appropriate care for persons with multiple chronic conditions. Examples include:

- **The Group Resource Line (GHRL):** staffed by 20 senior volunteers, this telephone hotline enables seniors, their families and GHC providers easy access to the wide range of services available to seniors both within GHC and in the community.

- **The Senior Resource Center:** printed materials and educational programs on a wide variety of topics are made available to seniors, their families and GHC providers through a library, by calling the GHRL or attending programs.

- **Special Delivery Transportation Program:** volunteer drivers offer frail seniors, who have no other means of transportation, rides to medical appointments and home from the hospital.

- **Senior Peer Counseling:** specially trained senior volunteers, supervised by GHC's Mental Health Department, provide short-term intervention to socially isolated seniors.

- **Senior Housing Cooperative:** GHC has assisted the Senior Caucus in establishing Silver Glen, a senior housing cooperative, that will provide independent living with health care services emphasizing preventive care and health promotion.

- **Healthy Futures:** funded by the Health Care Financing Administration, this demonstration project has provided preventive services for the elderly in 14 areas including exercise, home safety, nutrition, alcohol consumption, smoking, medication management and mental health. The early results are so promising that we are integrating several components of the program into the ongoing delivery of care to seniors.

- **Senior Flu Campaign:** GHC's immunization campaign targeted at senior enrollees has increased immunization rates from 35% to 65%.

- **Caregivers Support:** specially trained GHRL volunteers provide telephone support for caregivers of the frail elderly and discuss options available within GHC and in the community and outreach services are provided

through various GHC departments including Community Health Services, Mental Health and the Employee Assistance Program.

An article in HMO Magazine which describes the study is attached to the Statement for the Record.

PAYMENT REFORM

As previously noted, HMOs offer Medicare beneficiaries considerable advantages. On the other hand, enrollment under TEFRA contracts--while growing--is still limited. Of great concern today is the fact that a number of well-established HMOs with long experience with the Medicare program are encountering difficulties because of inadequate payment and are seriously considering shifting to other options such as cost contracts or Medicare wrap-around policies. While we understand discussion today has focused on HCFA oversight in the areas of marketing and quality, the issue of payment reform is also vital. It is a matter of crucial significance to many of the HMOs which have participated in this program the longest. If this issue is not resolved, you will have very few plans left in the program.

My own HMO is a case in point. We are seriously evaluating whether we can remain in the program. Our increase in 1991 was one of the lowest AAPCC payment reates in the country. Ironically this was duplicated in other parts of

the country such as Portalnd, Oregon and Minneapolis where HMO enrollment of Medicare beneficiaries is the highest. Our payment rate increased about 6.9% per members per month while inflation on Medicare basic services increased by 11%. Preliminary analysis also shows that the government payment for Part A services and for ESRD and the institutionalized does not cover the cost of the services. We are also experiencing adverse selection - on average, new Medicare beneficiaries which join our HMO are 10 years older than "age-ins" from employer groups. These new members are attracted by the comprehensiveness of benefits, particularly our prescription drug coverage.

As you know, we are one of the pioneers in the HMO movement. We believe in prepayment. We participated in the original HMO option allowed under the Medicare program before TEFRA was enacted. We believe Medicare beneficiaries should have access to HMO care and we will not give up our commitment to serving the elderly population. However, unless the current payment system is reformed, we may have to convert our contract status.

Because GHAA and its member plans believe so strongly in the merit of this Medicare option and in the advantages it offers to the Medicare beneficiary, we have spent and will continue to spend considerable time exploring how the current payment methodology might best be refined or replaced. We would like to review with you our conclusions and recommendations, recognizing that these are complex topics and

considerable additional work remains to be done. These conclusions are based on lengthy deliberations by GHAA's Technical Panel on Medicare Rating Reform, a group comprised of leading actuaries and technical leadership among our member plans with TEFRA contracts, and whose recommendations have been endorsed by GHAA's Government Affairs Council.

We have reached three conclusions:

(1) In the long run, the objectives of the Medicare program are most likely to be achieved by totally restructuring the Medicare TEFRA risk contract payment methodology, so that it is not linked to fee-for-service payments, but rather to the anticipated use of managing health care resources.

(2) An improved health status adjustment to payment rates is critical under both the current program and any new program to promote competition based on efficiency and equity to participating plans. Such payment adjustments are the best protection for everyone, including the government, that payment rates are appropriate and reflective of the individuals who seek to enroll in HMOs.

(3) There are a number of sound technical refinements to the current payment method which are feasible for HCFA to make in the 1993 rates.

Let me review each of these in turn.

The Desirability of Considering Total Restructuring of the Payment Methodology under the Medicare Risk Contracting Program.

When the original Medicare legislation was enacted, the political consensus favored the continuation of a fee-for-service system with little interference with traditional medical practice. While the limited opportunities for HMOs to participate in the program have been expanded over time, the current system continues to be largely fee-for-service driven and the available HMO payment methods heavily linked to the experience of Medicare's fee-for-service payment.

Under the current program, HMOs are paid 95% of the adjusted average per capita costs incurred by similar fee-for-service beneficiaries in each county. While designed to assure that HCFA pays no more than they would have paid had beneficiaries continued to be served in the fee-for-service sector, this approach to payment has a number of serious limitations:

- Payments to HMOs vary according to the relative efficiency or inefficiency of fee-for-service practice and access to Medicare providers in each locality, rather than an HMO's own costs or efficiencies. This reduces incentives for HMOs to participate in the program in low payment counties. The presence and

practice of HMOs influence fee-for-service practice, particularly in high penetration counties. To the extent the local costs are then lowered, HMOs in these counties are penalized by reduced AAPCCs. This also occurs because of other initiatives to reduce Medicare payments, such as the hospital prospective payment system and physician payment reform. The HMO gets a percentage of a shrinking base.

- o The current payment methodology departs considerably from commercial practice, thus adding to the administrative burden and costs of HMOs, reducing incentives for HMO participation, and reducing the ability of government to encourage enrollment in the most efficient plans. For commercial business, HMOs set premiums based on their anticipated costs of enrollees joining the plan; the employer or purchaser addresses its fiscal constraints by establishing an equitable employer contribution to each option and enrollees pay the rest. Most employees are offered multiple health options annually. This has a number of advantages: HMOs are allowed to set premiums so that they cover costs; purchasers decide on their financial liabilities; and incentives are created for employees to choose the most efficient plan that meets their needs.

GHAA's Technical Panel on Medicare Rating Reform currently is considering alternatives to the current method of HMO

payment under the Medicare TEFRA contracting program, with the anticipation of having two or three proposals in early 1992. Preliminary analysis suggests that a major new approach to determining capitation rates may be warranted to address these limitations and best meet the objectives of Congress, Medicare beneficiaries and HMOs.

Improved Health Status Adjusters Should be Incorporated into the Calculation of Payment Rates for HMOs.

In any program involving voluntary choice among a range of options, there are likely to be differences between people who join an HMO and those who do not. As long as these choices are voluntary on the part of the consumer and not influenced by plan behavior, such selection effects are appropriate and consistent with both competitive theory and the kinds of Congresional interests which developed the Medicare risk contracting program.

One of our concerns is to assure that the capitation rates appropriately compensate for selection effects. If an HMO attracts a more severly ill case-mix (adverse selection), it should not be underpaid. Conversely, if an HMO attracts a relatively healthier population, it should not be overpaid. A payment system should not inadvertently penalize or reward plans based on patient mix rather than their relative efficiency. Development of appropriate risk adjusters is critical, not just to Medicare, but to the design of any proposal for health care reform which provides Americans a choice of provider systems.

In this regard, GHAA was disappointed to learn that HCFA has decidied not to pursue further their demonstration with Diagnostic Cost Groups, the most developed form of risk adjuster for the Medicare program. We believe it would be worthwhile for the government to evaluate recent research on adjusting private employer contributions to employee health premiums, for possible application to the Medicare program.

SELECTION CONCERNS WITHIN THE MEDICARE RISK CONTRACTING PROGRAM

Although selection concerns have existed from the start of the Medicare risk contracting program, there has never been an appropriate study of this issue. And although a number of studies have been conducted, most have followed the same design and have been subject to the same flaws and limitations. The impact of these flaws has been to overstate estimates of favorable HMO selection within the program while failing to provide the empirical base of knowledge needed to properly understand selection effects and to identify the most appropriate policy responses to these problems.

THE DIFFICULTIES IN MEASURING SELECTION

There are a number of serious methodological problems involved in the design of selection studies of the Medicare risk contracting program. The most direct measure of selection--health or functional status--is not included in routine administrative records, expensive to measure, and unless carefully developed, subject to manipulation.

A commonly used proxy, utilization or cost, is inappropriate for currently enrolled individuals in HMOs because HMO performance influences these measures and because benefit differences also confound any comparison.

Because of these problems, most studies have focused on comparisons of new entrants into the HMO system, despite the fact that this excludes the vast majority of HMO enrollees in mature plans and does not capture the aging process inherent in continuously enrolled individuals. Prior use or cost measures also may be biased if those beneficiaries anticipating a switch in plan delay utilization pending a switch or because they are dissatisfied with their current providers. To the extent this occurs, the health status of "switchers" is overstated and pent-up demand is created which can add to the costs of new entrants once they switch plans, also referred to as "start up" costs. Such added costs also occur if better case finding in the new system results in additional conditions being identified which need treatment. In addition, prior use or cost measures are subject to "regression to the mean", a statistical phenomenon which occurs when large differences become more similar over time because of the role of chance. One study found, for example, that in a simulation of HMO favorable selection, Medicare lost money in the first three years but because of regression to the mean, early losses were recouped by the seventh year.

EVIDENCE ON SELECTION

The most comprehensive study of selection effects for Medicare risk enrollees was undertaken as part of the Medicare Competition demonstration evaluation. This study--whose results have been widely reported--concluded that HCFA paid between 15 percent and 33 percent more for beneficiaries enrolled in HMOs than it would have paid had those enrollees been served by the fee-for-service sector. Unfortunately, this analysis is based on the prior use methodology noted above and is subject to all the flaws inherent in that methodology.

In addition, the conclusion ignores the fiscal impact on plans of the improved access which is likely to result from enrollment in the HMO. Medicare beneficiaries who were poor (but not eligible for Medicaid), did not have prior Medigap insurance, and did not have a regular source of care, were four times as likely to join an HMO. Because of financial barriers to care, these individuals were likely to have lowered prior use; once enrolling however, the limited financial barriers that are part of the HMO delivery structure are likely to result in additional utilization to address existing health problems and pent up demand. Related study findings also show HMOs do a better job of routine care, with better medical history taking, more complete physical examinations, more screening tests, and greater frequency of immunizations. These practices also are likely to increase the initial expense of treating new enrollees in HMOs.

Existing studies of selection were conducted in the early phases of the Medicare risk contracting program, mostly when the program itself was only a demonstration. There are a number of reasons why it is difficult to generalize from this period to both the present and to the future.

Current HMO participants in the program represent a broader cross-section of the industry--they also are more likely to include IPAs, which research shows are less likely to evidence favorable selection. The current program does not allow for health screening, which was allowed under the demonstration.

Perhaps most significantly, the current program represents a more mature stage of development. Since the early demonstration phase, HMOs have become much better known. An increasing share of newly eligible Medicare beneficiaries had a choice of an HMO option while employed and hence may not have to switch providers to enroll under the Medicare risk program. Most importantly, a considerably higher share of Medicare enrollees represent continuously enrolled individuals. The most recent HCFA data indicates that approximately 914,000 of the 1.4 million current risk-based enrollees have been continuously enrolled in a risk-based plan for at least 12 months. Of this, 893,038 in the same plan. A total of 757,000 current risk enrollees were enrolled in an HMO for two continuous years. Epidemiology dictates that this population is likely to grow increasingly old and infirm. Over time, even if favorable selection exists, its effects are likely to

dissipate or even potentially reverse. This has happened, for example, in the Federal Employees Health Benefits Program, where the oldest participating plans tend to have higher percentages of annuitant enrollment.

THE CURRENT TEFRA EVALUATION

For the preceeding reasons, GHAA was extremely disappointed with the design of the current HCFA funded evaluation of the TEFRA program which was done by Mathematica Policy Research. Coming on the heels of a number of existing studies, this comparatively well-funded study had a unique opportunity to build on past experience to extend knowledge. Unfortunately, not only was that opportunity bypassed by the design of that study, the very design missed one of the most important contributions that study could have made to understanding how selection changes over time.

As noted previously, over four-fifths of all Medicare beneficiaries currently enrolled in risk based HMOs have been enrolled for at least a year. Yet the TEFRA evaluation focused only on new enrollees, thus ignoring not only the vast majority of enrollees but the very group which needs to be studied if the critical question of changes in selection over time is to be addressed. When questioned about this omission, HCFA staff point out that studies of current enrollees are difficult to undertake. While true, what good is a study if it ignores the most important questions which policy makers need answered?

We are similarly disappointed that the study made little effort, if any at all, to assess empirically the concerns HMOs have expressed about selection studies. It would have been extremely useful to have used the study to assess the role of pent-up demand, unmet need, better case finding, expanded Medigap coverage, propensity to consume and related factors influencing initial and later year cost experience for Medicare enrollees in HMOs. Yet these issues were handled incompletely.

As an industry, we believe that competition should be fair. Rates should appropriately reflect selection differences. For equity reasons, these adjustments should be on a plan-specific basis so that plans are neither rewarded nor penalized based on their enrollment mix. Despite the current studies, we remain unconvinced that favorable selection occurs within the Medicare population to the extent represented in the existing literature. We also believe that favorable selection is likely to dissipate over time as more experience is gained. We welcome working with Congress, HCFA and others on these issues to develop appropriate studies and measures for selection and appropriate tools for adjustment.

Technical Refinements to the Current Payment System Should be Made for 1993 Rates.

Through the work of GHAA's Technical Panel on Medicare Rating Reform, we have identified a number of specific proposals for refining the Medicare payment system which can be accomplished under existing statutory authority. We will be

discussing with HCFA specific proposals to: refine the geographical units used to calculate rates; better reflect the intent of Congress with respect to expenditures for working aged beneficiaries and those eligible to use Veteran's Administration facilities; and a number of other small technical refinements to the current payment system. We hope that these can be used in the 1993 rate calculations to strengthen the rate setting methodology, pending more fundamental reform.

QUALITY OF CARE

Recent studies comparing the quality of care in HMOs to that of the fee-for-service sector continue to confirm that HMOs provide care that at least equals and often surpasses the fee-for-service in quality. (A summary of these studies is attached to our written statement). Enrollees in HMOs benefit from greater access and use of preventive services and early detection/screening examinations and tests, and these results are true for both adults and children. Several studies have found that HMOs provide greater access to ambulatory care, and have concluded that early identification and treatment of health problems accounts in part for the lower hospitalization rates of many HMOs. HMOs have also been shown to be effective in managing patients with chronic illnesses-a recent study of adults with 17 chronic conditions conducted by RAND found that HMO enrollees had better overall quality of care than those in the fee-for-service sector.

In spite of consistently positive findings regarding the overall quality of care in HMOs, both in general and for the Medicare population, the industry is subject to greater scrutiny than the fee-for-service sector. For HMOs with Medicare TEFRA risk contracts, PROs review care provided in all settings--hospital and ambulatory. This is not the case in the fee-for-service sector where PRO oversight focuses only on in-hospital care and completely fails to address services provided in physicians' offices.

Ironically, this is one of the reasons there are lingering doubts regarding the quality of care in HMOs. The more intensive oversight of HMOs leads to the identification of isolated occurrences of problems which have been inappropriately generalized to the industry as a whole.

The HMO industry is not opposed to strong quality oversight processes, and, indeed, recognizes the potential benefits to be derived. It is our belief that external oversight of the accessibility and quality of care provides strong incentives to HMOs to continually improve their performance, and provides necessary protection to beneficiaries. We do, however, encourage the subcommittee to recognize the need for equivalent oversight processes in the fee-for-service sector and to work with us to help modify the current review system so that it is more appropriate to the HMO delivery system.

Quality oversight processes for HMOs should recognize the unique characteristics of their delivery system. Unlike the fee-for-service sector, HMOs accept responsibility for a defined population of Medicare beneficiaries and present a unique opportunity for the PRO to shift its focus in part, from individual cases to population-based quality measures (e.g., mammography rates). Population-based approaches are more likely to identify systematic problems in HMOs, that once resolved, will likely yield benefits to greater numbers of people. Population-based approaches do not completely eliminate the need to review individual cases. For example, if a plan exhibits an unacceptably low mammography screening rate, the next step would be to examine individual cases to ascertain why mammograms were not performed at appropriate intervals. Population-based approaches help to focus individual case review efforts and to assure that HMOs have systems to promote appropriate access to preventive, acute and chronic care.

HMOs also differ from the fee-for-service sector in that HMO providers are subject to formal peer review processes carried out by the HMO. External quality oversight processes should recognize this distinction, and should be designed to be complementary and supportive of an HMO's internal quality improvement program, not redundant or inconsistent.

The current PRO process is best described as an "inspection" process. A sample of cases is selected and an "inspector" reviews each one to identify possible problems. The process focuses on individual cases and individual

providers, not systems of care in which there is a defined enrolled population and a defined network of providers and support services, as is the case in an HMO.

Another problem with the current PRO program is that it imposes local fee-for-service standards and practices on the prepaid sector. Since fee-for-service is still the dominant mode of practice in the majority of communities, this mandate results in fee-for-service practices being applied to HMOs. This approach fails to recognize that HMOs are intended to modify medical practice; HMOs are by design expected to place greater emphasis on the provision of comprehensive, coordinated care, prevention and primary care, and on the elimination of unnecessary services or services of questionable value.

Large HMOs that are national or regional in scope find it particularly difficult to conform to a state-based PRO process. Many of these systems are striving to bring medical practice in line with the best available knowledge regarding efficacy, and by doing so, achieve a degree of consistency in medical practice across regions.

The PRO program's inspection approach to quality review is extremely costly and direct federal expenditures are only a part of the cost. To comply with PRO review, HMOs must increase both professional (R.N.) and clerical staff and incur significant costs associated with the copying and transporting of medical records to a central location for inspection by PRO staff. HCFA does reimburse HMOs for some of the costs of

copying (at a rate of $0.05 per page), but needless to say, this falls far short of actual costs. The medical record collection process can also be very complex logistically for HMOs that contract with large numbers of physicians in private practice and with multiple hospitals, home health agencies and other institutional providers.

Benefits derived from the current PRO process are questionable. The process is designed to identify the "bad apples" - not continuously improve the practice of the majority of physicians. Of all the cases reviewed by PROs, only a very small fraction were found to have serious patient care problems. It is difficult to justify continued federal and HMO expenditures in support of a program with such a low yield.

It is time for the PRO program to adopt a new strategy and this strategy should be at least consistent, if not synergistic, with the efforts of managed care organizations to build strong internal quality improvement systems. This is not to say that identifying incompetent or impaired physicians isn't important -- HMOs generally do this through their credentialing and recredentialing processes. But there is far greater potential to improve medical practice as a whole by focusing on the typical physician and creating an environment that will encourage continuous improvements in practice.

This "environment" is a managed care system that includes information for problem indentification, feedback and

monitoring; positive incentives for improving performance; strong clinical and managerial leadership; formal and informal peer review processes; and well-defined support systems for providing patient care with appropriate checks and balances.

The PRO program has thus far focused little attention on efforts to promote the development of strong internal quality improvement systems in HMOs. The current PRO program does provide HMOs with the option of undergoing a review of their internal quality assurance program, which if found to satisfy certain criteria, results in the HMO being granted "limited" review status. This is a step in the right direction, but unfortunately the "limited review" process has not been structured or implemented properly.

The most serious flaw in the limited review program is the absence of a strong external review process for assessing the adequacy of an HMO's internal quality improvement mechanisms.

Conducting external reviews of internal quality improvement programs is a complex process. Organizations with extensive experience in this area, such as the Joint Commission on the Accreditation of HealthCare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA), have invested a great deal in the development of standards, the training of reviewers, and the specification of a review process. It is not cost-effective nor desirable to have individual PROs develop such external review programs.

Greater centralization of the external review process is needed. Consideration should also be given to establishing mechanisms to insure that HMOs are not subject to multiple external review programs by the federal government, state governments, and private purchasers.

Major changes are needed in the current system to review quality of care in HMOs which contract under TEFRA. The PRO program began experimenting with alternative review processes that place greater emphasis on the development of strong internal quality improvement systems and the use of population level indicators of quality rather than the review of large samples of individual cases. It is also apparent that some consideration should be given to centralizing or regionalizing certain aspects of the PRO program.

MARKETING PRACTICES

As part of an effort to assure that HMO marketing practices are appropriate, GHAA has sponsored special educational conferences and seminars, developed printed materials and with the help of member plans, have developed "Marketing Guidelines" which have been endorsed by the GHAA Board of Directors. These activities all relate to marketing in general but also focus on serving special populations, such as Medicare beneficiaries. I would like to submit for the Record the full text of the GHAA Marketing Guidelines and our document on "Helping Older Adults Make Informed Decisions About Joining An HMO."

Let me highlight some of the key points from these latter two documents:

On Compensation

- The method of compensation should be structured to reward appropriate market conduct and safeguard against inappropriate market conduct.

- Compensation should be linked to performance standards that are objective and measurable.

- If the method of compensation includes payment of commissions, the greater the percentage of compensation paid through commissions, the more frequent and stringent the review of performance should be. A minimum time period during which enrollment must be maintained should be a prerequisite for payment of a commission. A participating provider shall not be eligible for payment of commissions for enrollment of new members.

On Sales Presentations

- Each presentation should be geared to the special needs of the audience. Factors to consider include age and language.

- Benefits, limitations and exclusions should be clearly explained and all key terms (e.g., effective date of

enrollment, use of plan providers, access to specialists and unauthorized care) should be defined.

- To reinforce important messages, it may be helpful to ask members of special population groups like Medicare and Medicaid who enroll on an individual basis, to sign a document indicating they understand key terms and plan provisions. This is particularly advisable in the case of potential members who there is reason to believe may have difficulty understanding requisite information.

- Visual aids and written material should be used to supplement oral presentations whenever possible.

On Verification/Ongoing Member Satisfaction

- Internal market conduct audit studies should be carried out periodically to insure compliance with plan protocols, state and federal market conduct standards, and GHAA guidelines.

- For members of special population groups who enroll on an individual basis, such as Medicare or Medicaid enrollees, the decision to enroll should be verified by a non-sales employee.

- The plan should track member satisfaction and periodically survey disenrollments to identify areas for improvement in marketing practices.

- Explain and review important terms - especially those that are commonly misunderstood. Make sure to cover lock-in clauses, effective date of enrollment, coverage limitations, out-of-area care, emergency care, access to specialists and unauthorized care. Translate jargon into easily understood language. For example, you might explain lock-in provisions this way:

  - Medicare will not pay anyone other than your HMO for your health care.
  - Your HMO will not pay for any unauthorized health service you obtain from doctors, nurses or others who are not under contract with your HMO (except for emergencies and urgently needed care that do not permit you to get to one of your HMO's providers).

- Explain how your HMO resolves complaints, and provide a toll-free customer service number.

- Encourage the potential enrollee to review all terms and discuss this decision with others who can offer advice, such as a spouse, children, doctors and social service providers.

- To reinforce the information you've discussed, leave materials behind for the potential enrollee, family and friends. Agree to mail materials if requested.

- Finally, provide a list of numbers that a potential enrollee can call to obtain additional information,

counseling and assistance. Local Area Agencies on Aging may be sources of useful information. You also might recommend that seniors write to the American Association of Retired Persons, to request HMO publications. Also, help potential enrollees get in touch with seniors already enrolled in the plan to find out how satisfied they are.

CONCLUSION

Mr. Chairman and members of the subcommittee, our statement today has covered a variety of issues of importance to this subcommittee, Medicare beneficiaries, HCFA and the HMOs which participate in this program. What I would like you to remember are the tremendous benefits to the elderly provided by this program. The advantages include improved access to basic services, additional health services that improve the quality of care and the quality of life for our senior citizens, and truly meaningful differences in out of pocket costs because cost sharing is reasonable and predictable. The HMO coordinates care, not just costs.

We don't believe isolated incidents or problems should derail such a program. As we have discussed, the HMOs which participate in this program must meet a variety of standards. GHAA fully supports strong oversight and compliance activity to assure that these standards are met. It is also important to remember that HMO Medicare beneficiary satisfaction rates remain high. We believe strongly that there are some issues in this program that deserve attention - such as payment reform and appropriate systems for review of quality of care. We look forward to working with you to address these problems and to assure that this is a program we are all proud to promote.

Mr. WAXMAN. Thank you.
Mr. Ehlen.

STATEMENT OF K. JAMES EHLEN

Mr. EHLEN. My name is Dr. James Ehlen. I am chairman and chief executive officer for MEDICA, a health maintenance organization covering over 530,000 members in the State of Minnesota. Over 80,000 members are served by our Medicare managed care program.

Before joining MEDICA, I was a practicing endocrinologist for 12 years. I am involved with the Minnesota Council of HMO's, including having most recently served as chairman. In addition, I participate as a member of the Rand Corporation clinical subcommittee study on quality assurance.

I am pleased to be here today on behalf of the over 500 members of the American Managed Care and Review Association—or AMCRA—which is the national trade association for the managed care industry. Over 650,000 Medicare beneficiaries are served by a health plan run by an AMCRA member.

We appreciate the willingness of the chairman and the members of the committee to focus their attention on the Medicare managed care program. As we all recognize, there is a growing interest in managed care, both in the public and private sectors.

While we recognize the desire to focus on the continual improvement to the operations of the program, such a discussion should not ignore the significant contributions and benefits that have been accrued by all participants in the Medicare managed care program—especially Medicare beneficiaries.

The Medicare program current serves approximately 34 million beneficiaries. About 2 million receive health care through a Medicare managed care program, and the remainder are enrolled in the traditional fee-for-service program.

If I could choose three things for you to take away from the hearing today, they would be:

First, studies have shown that the quality of care in the Medicare managed care program is as good as or better than Medicare fee for service;

Second, research shows that Medicare managed care enrollees are more satisfied with their health care plan than are their fee-for-service counterparts; and

Third, the Medicare managed care payment rates no longer make sense and are seriously jeopardizing the program.

Quality of care issues are paramount for those of us in the health care business. Managed care, however, recognizes that spending more on health care services is by no means indicative of the quality of care received. In health care, more is not necessarily better.

Congressman Stark also recognized this fact. In hearings before the House Ways and Means Subcommittee on Health in April of this year, he said:

> While the volume of services and expenditures are growing rapidly, substantial evidence suggests that many patients are receiving health care that is ineffective. . . . Many Medicare patients receive care they don't need, while others don't receive the care they should.

Managed care programs confront the misconception of poor quality of care by undertaking internal quality assurance mechanisms unheard of in the fee-for-service sector. Recent studies indicate there is no empirical basis for the claim that quality of care is compromised in managed care settings. Much of the research jointly being pursued with the Health Care Financing Administration has begun to focus on the delivery of services to Medicare beneficiaries.

These studies have found the quality of care in managed care is as good as, if not better than, in fee for service and that recommended elements of routine and preventive care are more likely to occur in managed care.

The studies are only the beginning. Managed care has and will invest significantly towards public and private research to identify quality indicators and establish medical practice guidelines which will continue to guide our delivery of quality, affordable health care services.

Medicare beneficiaries enrolled in managed care programs receive far greater services than are available to their counterparts in fee for service. This includes additional health services like preventive care, wellness programs, prescription drug services, eye and ear exams, hearing aids, and immunizations; and these services are often provided at significantly lower premiums, copays, and deductibles.

A satisfied patient is important to us. We clearly recognize that Medicare beneficiaries have the opportunity of choice, be it between fee for service and managed care, or between managed care programs.

Satisfaction keeps members enrolled and leads members to recommend our services to others.

In May of this year, AMCRA set out to determine how satisfied Americans were in their managed care plans versus those in traditional health insurance. The widely respected Gallup Organization was commissioned to conduct a comprehensive study of the American public's satisfaction with their health care delivery system.

Generally, while members of both groups are satisfied with the way they receive health care services, seniors are significantly more satisfied with managed care than with fee for service.

The survey findings also provide us better insight into the driving factors that lead members to consider switching plans. Clearly, the leading factors were cost-related—expenses, refused bills, high deductibles, high copays, or rate increases. In fact, the study confirmed that even a small premium increase of $5 per month would provoke a member to switch.

The survey provides us a better appreciation of the importance of the physician-patient relationship. Managed care members are significantly more likely than their fee for service counterparts to indicate they would change plans if their doctor disaffiliated from their plan.

This finding documents preservation of a strong patient-physician relationship in the managed care setting. Based on this relationship, a Medicare beneficiary will often make a choice between fee for service or managed care.

To sum up the findings of the Gallup poll, managed care enrollees are more satisfied than their fee for service counterparts. And,

we believe, as more of the employed population familiar with managed care becomes Medicare eligible, there will be an increasing receptivity to Medicare managed care programs.

Finally, a comment on payment ratesetting. Managed care has found a role in many communities across the United States.

Medicare beneficiaries enrolled in managed care plans are more and more reflective of the diverse demographics and health status of the Medicare population nationwide.

The Gallup Poll confirms this. However, mischaracterizations continue to exist. Among these, payment rate methodology is one of our most challenging dilemmas. The urban study provides us the most disturbing glimpse of the barrier threatening the expansion of the Medicare-managed program.

Namely it is this: The more efficient managed care makes fee for service the more efficient the payment rates becomes. Better recognition of cost savings reflected in more appropriate fee structures is needed to sustain this program.

We believe that Congress, HCFA and the industry are equally frustrated with this matter and look forward to finding the best way to serve our beneficiaries. Choice in health care, both in financing and delivery, is an integral part of our health care system.

For the first time ever, in 1985, Medicare beneficiaries were given the choice on how they could receive their Medicare-covered services.

Two million Medicare beneficiaries have chosen to receive it through Medicare managed care. And, as important, they always maintain the right to choose to continue this relationship based on the elements that are most important to them.

We are well aware of the responsibility and sometimes the inherent problems that arise in marketing plans to beneficiaries. In the public as well as private sector, managed care has demonstrated itself as a better value for every health care dollar spent.

Managed care demonstrates that it is as good, if not better, than fee for service. It has received continual endorsement as the Gallup Poll indicates. We cannot overlook the contributions and benefits resulting from these programs.

Our issues and goals are the same, affordable, cost-effective health care. We look forward to working together and to address our challenges together as we reach our goals.

Thank you for this time. I would be happy to answer questions.

[The prepared statement of Mr. Ehlen follows:]

Statement of Dr. K. James Ehlen
Chairman and Chief Executive Officer
MEDICA

AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

INTRODUCTION

Mr. Chairman and Members of the Committee.

My name is Dr. James Ehlen. I am chairman and chief executive officer for MEDICA, a health maintenance organization covering over 530,000 members in the state of Minnesota. Over 80,000 members are served by our Medicare managed care program. Prior to joining MEDICA, I was a practicing endocrinologist for 12 years. I am actively involved with the Minnesota Council of HMOs, and most recently served that group as chairman. In addition, I participate as a member of the Rand Corporation clinical subcommittee study on quality assurance.

I am pleased to be here today on behalf of the over 500 members of the American Managed Care and Review Association (AMCRA). By way of background, AMCRA is the national trade association for the managed care industry. AMCRA's membership includes health maintenance organizations (HMOs), competitive medical plans (CMPs), preferred provider organizations (PPOs), independent practice associations (IPAs), utilization review organizations (UROs), and other entities that offer managed health care services. More than 650,000 of AMCRA member enrollees are in the Medicare managed care program.

We appreciate the willingness of the Chairman and Members of the Committee to focus their attention on the Medicare managed care program. As we all recognize, there is a growing interest in managed care both in the private and public sector. And, while we recognize the desire to focus on continual improvement to the operations of the program, we feel that such a discussion should not ignore the significant contributions and benefits that have been accrued by all participants in the Medicare managed care program -- especially the Medicare beneficiaries.

BACKGROUND

The Medicare program currently serves approximately 34 million Medicare beneficiaries. Approximately 2 million receive their care through a Medicare managed care program, and the remainder are enrolled in the traditional fee for service program.

If I could choose three things for you to take away from the hearing today, they would be:

> First, studies have shown that quality of care in the Medicare managed care program is as good as or better than Medicare fee for service;
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> Second, research shows that Medicare managed care enrollees are more satisfied with their health care plans than are their fee for service counterparts; and
>
> Third, Medicare managed care payment rates no longer make sense and are seriously eroding the confidence in the program.

QUALITY OF CARE: BEYOND FEE FOR SERVICE

Quality of care issues are paramount for those of us in the health care business. Managed care, however, recognizes that spending more on health care services is by no means indicative of the quality of care received. In health care, more is not necessarily better.

Recognition of this fact was provided by Congressman Pete Stark in April of this year in hearings before the House Ways and Means Subcommittee on Health when he said,

> "While the volume of services and expenditures are growing rapidly, substantial evidence suggests that many patients are receiving health care that is ineffective . . . Many Medicare patients receive the care they don't need, while others don't receive the care they should."[1]

RESEARCH ON MEDICARE MANAGED CARE VS. MEDICARE FEE FOR SERVICE

Managed care programs confront the misconception of poor quality of care by undertaking internal quality assurance mechanisms unheard of in the fee for service sector. Recent studies, including a 1989 Institute of Medicine, indicate there is no empirical basis for the claim that quality of care is compromised in managed care settings.[2] Much of the research jointly being

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[1] Stark, Pete. Statement before the U.S. House Ways and Means Subcommittee on Health, April 30, 1991.

[2] Committee Utilization Management by Third Parties, Division of Health Care Services, Institute of Medicine, Controlling Costs and Changing Patient Care? The Role of Utilization Management, (1989).

pursued with the Health Care Financing Administration (HCFA) has begun to focus on the delivery of services to Medicare beneficiaries. This research finds that the quality of care in managed care is as good as if not better than in fee for service.

To illustrate, Dr. Sheldon Retchin of the Medical College of Virginia studied elderly patients with congestive heart failure (CHF), a chronic condition that frequently occurs in the elderly. Dr. Retchin's study compared the care of patients under prepaid care versus fee for service Medicare. The study concluded that,

> "HMOs enhance the continuity between hospital and ambulatory settings for patients discharged following CHF."[3]

The findings further conclude that outpatient evaluation and management was similar in both settings, although HMO providers were significantly more likely to advise reducing salt intake and were more likely to schedule follow-up exams within one week of discharge.

Other studies have reviewed conditions that most commonly afflict the elderly in order to examine the quality of care delivered in managed care programs versus fee for service.

One 1990 study on ambulatory care suggested that individual items of medical histories and physical examination were performed most often for HMO patients and least often for fee for service patients. The results suggested that recommended elements of routine and preventive care are more likely to be performed for Medicare enrollees in HMOs than in fee for service settings.[4]

Another study released in 1991 reviewed the management of geriatric hypertension in the outpatient setting and compared fee for service patients to HMO patients. The study concluded that, using criteria established by a panel of expert physicians, HMO patients consistently received more extensive history-taking, physical examinations, and laboratory workup pertinent to hypertension relative to their fee for service counterparts.[5]

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[3] Retchin, S. and Brown, B., The American Journal of Medicine, "Elderly Patients with Congestive Heart Failure Under Prepaid Care," February 1991, p. 236.

[4] Retchin, S., and Brown, B., American Journal of Public Health, "Quality of Ambulatory Care in Medicare Health Maintenance Organizations," Volume 80, 1990, p. 411-415.

[5] Preston, J.A., and Retchin, S. M., Journal of the American Geriatrics Society, "The Management of Geriatric Hypertension in Health Maintenance Organizations," (at print in May of 1991.)

Both public and private research identifying quality indicators and establishing medical practice guidelines is continuing. The managed care industry is investing in these areas, and we recognize we cannot and should not work in a vacuum away from the fee for service sector. We support the continued investment -- by both the public and the private sectors -- in quality indicators, medical practice guidelines, and technology assessment.

Thus far, all signs point to the fact that quality of care in the HMO environment is as good as, if not better than, fee for service.

BENEFICIARY ADVANTAGES UNDER MEDICARE MANAGED CARE

Medicare beneficiaries enrolled in managed care programs receive far greater services than are available to their counterparts in fee for service. These health services include preventive care, wellness programs, prescription drug services, eye/ear exams, hearing aids, and immunizations. And, these services are often provided at significantly lower premiums, copays and deductibles.

A quick glance at today's headlines underscores the costs and confusion that arise from the duplication of paperwork in health care matters. The provision of additional services often makes it unnecessary for a Medicare enrollee to maintain a Medicare supplement policy, thereby eliminating unnecessary paperwork. There is no need to file a second claim to a Medicare supplement carrier, nor is there the necessity of learning another system of Explanation of Benefits (EOBs) from the fiscal intermediary and the Medicare supplement carrier.

PROVISION OF SOCIAL SERVICES

Managed care programs also provide "social services" that assist and educate Medicare beneficiaries in attaining affordable, accessible health care. For example, MEDICA communicates on a quarterly basis with members enrolled in our Medicare managed care plan to inform them of the necessity of routine preventive care, where to go or who to call to access health care services, and miscellaneous other health care related subjects.

Other Medicare managed care plans also provide transportation for Medicare beneficiaries to and from their appointments -- a service that not only benefits the patient by ensuring they receive health care services, but also benefits our providers by ensuring that appointments are kept and necessary health care services are delivered. These "social services" are above and beyond what is available to 97 percent of Medicare beneficiaries in fee for service, yet **HCFA pays no additional cost for the provision of these services**.

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BENEFICIARY SATISFACTION WITH MANAGED CARE

A satisfied customer is important to us. We clearly recognize that Medicare beneficiaries have the opportunity of choice -- whether between fee for service and managed care or between two managed care programs. Satisfaction keeps members enrolled, and leads members to recommend our services to others.

In May of this year, AMCRA set out to determine how satisfied American were in their managed care plans versus those in traditional health insurance. The widely respected Gallup Organization was commissioned to conduct a comprehensive study of the American public's satisfaction with their health care delivery system.[6]

The survey found that enrollees of both groups are generally satisfied with the way they receive health care services, although seniors are significantly more satisfied than are younger Americans -- 85% of seniors are satisfied with their health care system versus 79 percent for Americans of all ages. And, on the tendency of seniors to recommend their health delivery system to others, managed care members were significantly more likely to recommend their program than were those in traditional fee for service (91% likely with managed care versus 85% likely with fee for service.)

However, the survey findings provided us with better insight into the driving factors that lead members to consider switching plans. When respondents were asked to describe the main reason they would consider changing plans, cost-related factors were dominant. Among traditional plan members, 56% cite expenses, refused bills, high deductibles, high co-pays, or rate increases. For managed care enrollees, the comparable statistic is 50%.

Additional survey findings confirmed the role premium increases have in causing plan defections. Even a small increase of $5 per month provokes a "switch" reaction. These results are especially important to the Medicare program: the Medicare beneficiary in managed care can choose between fee for service or possibly another Medicare managed care plan, but a Medicare beneficiary wanting to switch from fee for service Medicare cannot go to another fee for service program.

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[6] The Gallup Organization, "A National Survey of U.S. Health Plan Consumers," Final Report, May 1991.

Further, managed care members are significantly more likely than their fee for service counterparts to indicate they would change plans if their doctor disaffiliated from their plan. This finding clearly demonstrates the prevalence of a strong patient-physician relationship in the managed care setting, and is once more indicative of the choice that a Medicare managed care program brings to the Medicare beneficiary. The patient-physician relationship impacts the choice a Medicare beneficiary will make between fee for service or managed care, or among managed care plans.

To sum up the findings of this poll, **managed care enrollees are more satisfied with their health care than are their fee for service counterparts**. And, we believe, as more of the employed population that is familiar with managed care become Medicare eligible, there will be an increasing receptivity to Medicare managed care programs. A full analysis of the survey findings will be made available to the Committee.

MISCONCEPTIONS OF MEDICARE MANAGED CARE

Managed care is, after all these years, still the unknown health care provider. While managed care has taken root in certain communities across the U.S. -- particularly the Southwest and in Minnesota -- it is still an area prone to mischaracterization by many. These misconceptions divert attention away from expanding and promoting the program.

Dispelling the mistruths and rumors surrounding managed care is a non-stop proposition. For instance, Medicare law does not permit managed care plans to health screen its enrollees, although such a practice was allowed in the early demonstration stages of the program. Nevertheless, stories of Medicare beneficiaries being health screened and denied enrollment in Medicare managed care plans are continually resurrected.

The fact is that Medicare beneficiaries who have enrolled in managed care plans are more and more reflective of the diverse demographics and health status of the Medicare population nationwide. The Gallup poll confirms this statistic.

PAYMENT RATES

Such misconceptions form the basis for the most challenging problem facing Medicare managed care: payment rates for managed care plans. Several studies have attempted to put this in perspective:

* Milliman and Robertson conducted a study on the adequacy of Medicare managed care payment rates in a study commissioned by the Department of Health and Human Services (DHHS). They found that the

  "1987 error in Part B, based on current estimates, equals almost a 5% error in <u>total</u> (Part A and Part B) program costs, making a 95% Adjusted Average Per Capita Cost (AAPCC) more like a 90% AAPCC."[7]

* The Urban Institute released a report in February 1991 that indicated a disturbing trend for the Medicare managed care contractors whose payment rates are based on a fee for service base. According to the report,

  "The results suggest that HMOs <u>decrease</u> Medicare expenditures: every 10 percentage points of HMO market share decreases Medicare expenditures by 1.2 percent in the short run and as much as 3.9 percent in the long run."[8]

The Urban Institute report further attributed the decrease in Medicare expenditures to the impact of the IPAs that contract with the Medicare program. IPAs represent the majority of Medicare beneficiaries in managed care as well as over half of the general HMO marketplace. Because IPAs allow physicians to treat both HMO patients and fee for service patients there is a spillover effect with physician practice patterns.[9] **<u>The study provides a disturbing glimpse of the barrier threatening the expansion of Medicare managed care programs: the more efficient the managed care program makes fee for service Medicare, the lower the managed care payment rates become.</u>**

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[7] See HCFA's Report to Congress of its Recommendations on the AAPCC and ACR (Appendix B, Milliman and Robertson Report at 70). HCFA's report was delivered to Congress on October 14, 1988.

[8] Welch, P. W., The Urban Institute, "HMO Market Share and Its Effect on Local Medicare Costs," February 1991, (Abstract).

[9] Welch, P.W., The Urban Institute, "HMO Market Share and Its Effect on Local Medicare Costs," February 1991, p. 4.

Medicare managed care payment rates no longer make sense and are seriously eroding the confidence of those in the managed care industry. The 1992 AAPCC payment rates give pause; in our service area of Hennepin County, Minnesota, Part A rates went up 13 percent, while Part B rates went down 7 percent. Such inconsistencies undermine the effectiveness of the program by raising questions regarding the long-term intentions of the regulators. We seriously believe Congress, HCFA, and the industry are equally frustrated on this matter, and look forward to finding the best way to serve beneficiaries who rely on us for the provision of their health care.

CONCLUSION

Choice in health care -- both in the financing and delivery of care -- is an integral part of our health care system. For the first time ever in 1985, Medicare beneficiaries were given the choice in how they could receive their Medicare covered services. 2 million Medicare beneficiaries have chosen to receive their services through Medicare managed care. And, as important, they always maintain the right to choose to continue this relationship based on the elements that are most important to them.

We are well aware of the responsibility, and sometimes the inherent problems, that arise in marketing plans to Medicare beneficiaries. Congressional response requiring pre-approval of marketing materials as well as prohibition of certain deceptive marketing practices recognizes the sensitivity to marketing abuses. In addition, AMCRA will continue to work in cooperation with HCFA, industry groups, and consumer groups to ensure ethical marketing practices.

In the public as well as the private sectors, managed care has demonstrated itself to be a better value for every health care dollar spent. Managed care has demonstrated that quality of care in the managed care setting is as good as if not better than fee for service. Managed care has received the continued endorsement of the public as Gallup poll satisfaction levels indicate.

Our issues are the same, and our goals are the same: affordable, accessible health care. We look forward to working together to address our challenges and to help reach our goals.

Finally Mr. Chairman, I must express my frustration with the process surrounding the distribution of the GAO report being discussed today. It would have been my preference to address the particular points of the report in my testimony today. However, the report was not made available to the public in time to be incorporated in my remarks submitted to the Committee.

Thank you for your time. I would welcome any questions you may have.

Mr. WAXMAN. Thank you. Mr. Davis, you made reference to the development by GHAA of marketing guidelines for HMO's. It struck me that many of these guidelines that have been reported today, would GHAA support the guidelines in HCFA regulations or in law?

Mr. DAVIS. I don't know that we have considered that, but I think we probably would, sir.

Mr. WAXMAN. Let met ask both of you if you have any recommendations about how HCFA should implement the OBRA 90 restrictions on the amount of financial risk that should be borne by physicians in HMO's.

Mr. EHLEN. The issue of physician risk has come up over and over again this morning. It is a very complicated matter. As a former provider, I can tell you some doctors are very comfortable in assuming financial risk on behalf of their patients, and others are less comfortable.

It is a complicated question. In many cases, we must identify where risk should not be borne by physicians and protect them from the pitfalls that we have seen demonstrated this morning.

In other cases, I think there are very appropriate mechanisms where financial risk can be given to the physician, and out of that, we can secure high-quality health care for our beneficiaries.

Mr. WAXMAN. Do you think the only way is to be at risk, or is there some ethical standard a physician would undertake if he did not have this conflict?

Mr. EHLEN. No. I believe strongly the drives to decisionmaking are more important than risks of malpractice causing a situation. The financial risk is a variable but a secondary one.

Mr. WAXMAN. It is a second that we need to put in place.

Mr. EHLEN. Yes.

Mr. DAVIS. The reverse incentive is inside the equation, Mr. Chairman. So, there needs to be a balance struck. The problem is how to balance the risk issues.

Mr. WAXMAN. Both of you testified about the problems of coordinating internal and external quality assurance programs. AARP noted some of these same problems, but recommended that HMO's be required to submit their internal quality assurance programs for review by PRO's.

Will your organization support such a requirement, and if not, how would you propose that an internal HMO quality assurance program be evaluated?

Mr. EHLEN. I would support, from my own organization's standpoint that recommendation, and also point out that in many cases, I believe the internal quality assurance programs that have been developed and are implemented on a day-to-day basis are far more effective than those we have seen through PRO's.

We need to tap that resource that they provide and take advantage of it, rather than see it as something we simply need to require.

Mr. WAXMAN. Mr. Davis.

Mr. DAVIS. This is Leslie Rose of GHAA.

Ms. ROSE. I am the legislative director for GHAA. We agree that review of the quality assurance program be a part of the quality of

care review. Unfortunately, we don't think that having its PRO's do that review is the proper way to go at this time.

There are adequate standards in place for how to review the internal QAP's. The reviewers who work for the PRO's may have little knowledge of the HMO, and may not be properly trained.

There is a great deal of variation now in how the PRO's are reviewing the QAP's. There is JCHO and NCQA, who have developed considerable time in looking at these programs.

So, we would support mandatory review of the internal QAP, but we don't necessarily believe that grafting it on to the current PRO system is the way to go.

Mr. WAXMAN. I appreciate your testimony. We will look forward to working with you as we continue our legislative oversight. Thank you for being here. I would like to insert in the record a statement by Congressman Pete Stark on this question.

Let me announce that there may be questions that members of the subcommittee may direct in writing to witnesses as well as statements for the record. We will hold the record open.

That concludes our business today. We stand adjourned.

[Whereupon, at 12:05 p.m., the hearing was adjourned.]

[The following statements and letters were submitted for the record:]

STATEMENT OF
THE HONORABLE PETE STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS

SUBMITTED FOR THE RECORD
TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON ENERGY AND COMMERCE
November 15, 1991

Mr. Chairman, I am pleased to have the opportunity to submit testimony for the record for your hearing on Medicare's program of risk contracting with Health Maintenance Organizations (HMOs). I want to commend you for scheduling this important hearing.

We have now had almost ten years of experience with Medicare's risk contracting program. This hearing provides an excellent opportunity to review what we have learned thus far.

First, I think it important to point out that Medicare is a public program. Medicare beneficiaries do not complain to the private companies operating HMOs when something goes wrong, even when the private company is at fault; instead, they complain to the Congress. This situation is analogous to a company with 35 million stockholders and a board of directors with 535 members.

Turning over control of this public trust to private concerns, no matter how enlightened they may be, is not a step to be taken lightly nor precipitately.

Risk contracting is a good, but not entirely proven, strategy. Although the program has grown fairly rapidly, it is still relatively small with a little over 1 million Medicare beneficiaries in risk contract programs currently. Less than one-third of all federally-qualified HMOs participate in the risk program.

It is also important to note that HMOs and other managed care programs such as PPOs are not equal. Some are long-established nonprofit organizations with rigorous standards; others were set up virtually overnight by people who only want to make a profit.

Most importantly, there are still questions about HCFA's ability to manage the current HMO system.

We all remember the problems HCFA had with IMC in South Florida. IMC was HCFA's largest demonstration program. Although HCFA took tough action at the end to deal with the IMC problem, it took a public outcry by Members of Congress and a GAO report for HCFA to take action.

Now we have the latest in a series of GAO reports detailing serious deficiencies in the oversight of HMOs by HCFA. GAO investigated actions by HCFA to resolve problems with the Humana Gold Plus HMO in South Florida, the successor to IMC, in response to a series of articles in the Fort Lauderdale Sun Sentinel.

The articles alleged that Humana Gold Plus was not informing potential senior citizen members that enrolling in the plan would mean that members could receive health services only from the plan. The articles also alleged that the plan was enrolling senior citizens without their knowledge.

The GAO verified these reports and confirmed other severe problems (all of which have now been corrected according to Humana.) The plan also had contracts with doctors that placed so much financial pressure on physicians that they may have withheld essential medical services. The plan also failed to give its enrollees appeal rights, thus subjecting Medicare beneficiaries to tens of thousands of dollars of expenses that the plan should have covered. The investigation revealed that HCFA knew of these abuses as early as 1987, but took no corrective action.

The amazing thing about this GAO report is that even though HCFA knew problems existed with HMOs in South Florida, they didn't act and seniors lost as a result. HCFA needed the press to point out the continuing abuses in order to act.

Humana Gold Plus and its predecessor, I.M.C., have had a long, troubled history. There are more Medicare beneficiaries enrolled in Humana Gold Plus than in any other plan. If ever there was a plan over which HCFA should have been exercising the most intense oversight, Humana Gold Plus was the one. This situation brings into question HHS's routine oversight of all the other HMOs. Does HCFA know what is happening to Medicare's HMO enrollees elsewhere in the nation?

IMC and Humana Gold Plus have not been the only problem organizations in the risk contracting program, although they have received the most attention. A study by Mathematica and the Medical College of Virginia also found that HCFA has problems in assuring that HMOs market their services properly, a finding supported by the recent GAO report.

A 1985 survey of 305 Medicare beneficiaries from 17 of the 20 organizations surveyed showed that 23% of them got out of the plans because "they had not understood the HMO arrangements" when they enrolled initially. An August 1988 GAO report found that "HCFA's staffing for compliance monitoring, although increased, has not kept pace with HMO growth." In that report GAO also questioned HCFA's ability to monitor HMO quality assurance activities.

Quality assurance is still the most critical issue. Serious questions about HMO quality remain. The Mathematica study noted that 5 of the 20 HMOs studied described "elaborate" quality assurance plans in their Medicare contract applications but never put the plans in operation; The Mathematica study also indicates that HCFA's review of quality assurance plans is often only a paper exercise.

Mr. Chairman, many HMOs do an outstanding job of providing health services to Medicare beneficiaries. But the new GAO report and the other evidence I have presented today indicates that the risk contracting progam still has a long way to go before it becomes the method of choice for providing Medicare benefits to seniors.

The Administration is continually trying to push more and more seniors into HMOs. The problem is that report after report has demonstrated that HHS is neither capable of protecting seniors, nor separating the good from the bad in HMO practices. We need to assure ourselves that quality can be guaranteed before we blindly allow this program to expand much beyond its current size.

I intend to introduce legislation in the near future expanding the Secretary's ability to impose intermediate sanctions on HMOs which are out of compliance with Medicare law.

However, I regret to say that the problem is not likely to be resolved completely by new legislation; there is plenty of authority on the books which is not being vigorously enforced. I therefore challenge the Administration to come up with the kind of hard-nosed, regulatory program we need if we are to assure that the kind of abuses detailed in this latest report are not ever repeated.

Mr. Chairman, thank you for the opportunity to submit this testimony. I look forward to working with you and all of the Members of your Subcommittee in this important effort.

Testimony submitted by the Honorable E. Clay Shaw, Jr.

To the Subcommittee on Health and the Environment
of the
House Committee on Energy and Commerce

November 15, 1991

Mr. Chairman, I'd like to thank you for calling this hearing today on the role Health Maintenance Organizations (HMOs) have in providing health care for Americans. As we all know, health care has become an issue on which Americans are demanding action. It seems to me that they are primarily concerned about problems resulting from the dramatically rising cost of health care in the United States. HMOs offer one approach to limiting costs, and any innovation that promises to save money without diminishing the quality of patient care deserves our serious attention.

Many have pointed to the recent Senate election in Pennsylvania as a referendum on national health insurance or simply on the need for reform of our current health care system. I don't believe that health care was the only issue involved, or that health care was the one issue that decided that race. Still, people are rightly concerned about skyrocketing medical costs. Those costs are threatening Americans' personal savings, their company's and our nation's competitiveness, and ultimately everyone's access to quality health care.

Health care cost inflation is driven by a number of factors: rapid and expensive advances in medical technology, stifled market forces, insurance mandates, medical malpractice costs, and the bureaucratization of the health insurance and billing system.

We have only started to experiment with ways to control costs and streamline the way health care is provided and paid for in the United States. To the degree that government and business have tried to control costs, we have turned primarily to some sort of managed care, especially as provided in HMOs.

Millions of American workers are currently making their annual decision about which health care plan is best for their family. Rapid health care cost inflation over the past generation is dictating that increasing numbers will select the least expensive, and sometimes the only affordable, option offered. For many, that means an HMO.

In some areas, the percentage of the population enrolled in HMOs is quite high. For example, in 1989 that figure was 72 percent in the District of Columbia, 29 percent in California, and 24 percent in Massachusetts.

In my home state of Florida the percent of the population enrolled in HMOs of any kind in 1989 was 10 percent, slightly below the national average of 13 percent enrollment. Among Medicare HMOs, which serve America's seniors, the Humana Gold Plus Plan is by far the largest in Florida, with over 200,000 enrollees. In fact, the Gold Plus Plan is the largest Medicare HMO in the country.

That is why today's hearing is so important. The marketing and enrollment problems uncovered in the Gold Plus Plan and other Medicare HMOs recently investigated in South Florida must be solved, period. Seniors are disproportionately dependent upon health care, and it is unconscionable to allow abusers who prey on seniors to go unpunished.

I represent Broward County, Florida. The federal taxpayer pays Humana and other Medicare HMOs operating in my district $429 every month to provide quality care for each Medicare beneficiary enrolled. That's $429 whether or not the beneficiary uses HMO services. With rapid growth in HMOs and Medicare HMOs expected in the coming years, it is absolutely imperative that consumers of all ages are confident in the quality of the service they receive.

That involves awareness and strict enforcement of current and future regulations, which is certainly within our ability to attain. HMOs, federal and state governments, and health care consumers all have a responsibility there.

One of the lessons we must take from this hearing is the need for immediate action to resolve oversight problems. Participation in Medicare HMOs, while growing, is still relatively small, with only 1.4 of 33 million Medicare beneficiaries currently enrolled. While those numbers are still manageable, the federal government must take steps to stop any abuses in the system, period.

Even if abuses are eliminated, difficult questions remain. Is there any way to hold down costs without rationing care, as is the HMOs unstated mission? Further, Americans have to come to grips with the fact that, for most of us, health care reform will probably mean higher taxes and an expanded role for the federal government.

Currently, Americans enrolled in HMOs participate by choice, reasoning, perhaps by financial necessity, that they receive an acceptable level of care for a relatively affordable price. Will the 87 percent of Americans not currently enrolled in an HMO, many of whom have traditional fee-for-service employer-provided plans, accept such limits?

Maybe more importantly, if health care costs continue to grow at their current pace, will they have any other option?

Comments

of

FHP, Inc.

Introduction

FHP, Inc. is a federally qualified health maintenance organization with over 640,000 enrollees. Of those, over 220,000 are seniors enrolled in three Medicare risk contracts in California, Arizona and New Mexico. As the second largest Medicare risk contractor in the nation, the FHP system provides its members much needed access to affordable and quality health care and, according to our estimates, saves Medicare beneficiaries and the federal government hundreds of millions of dollars annually. These savings result from the fact that FHP provides health care for a fixed amount of dollars and provides services above and beyond those provided under fee-for-service Medicare.

As the members of the Subcommittee turn their attention to the Medicare Risk Contracting Program, it is important to focus on three key issues: Quality, Consumer Satisfaction, and the Future of Risk Contracts. At the onset it is important to note that in the first two areas – quality and consumer satisfaction – there is very little substantive controversy. Study after study[1] has shown that the quality of care provided in a managed care setting is equal to or better than fee-for-service and, according to a recent Gallup poll, that consumers are generally more satisfied with managed care than their counterparts in the fee-for-service sector. However, in discussions of the future of the program serious misperceptions, regarding members' health status and plan payment rates, tend to undermine efforts to develop strategies which will guarantee the future of the program. Despite evidence to the contrary, the notion persists that plans are generally overpaid because their enrollees are generally younger and healthier than their peers in the fee-for-service sector.

FHP's Medicare Program

Before discussing these key issues it would be helpful to discuss FHP's delivery system and present the findings of an FHP analysis of the program savings that the Company undertook earlier this year.

First, FHP does not charge Medicare beneficiaries a monthly premium for a basic

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[1] See testimony before the Subcommittee by Dr. K. James Ehlen on behalf of the American Managed Care and Review Association and Aubrey Davis, on behalf of the Group Health Association of America, Inc.

benefit plan. One of the basic tenets of risk management is spreading risk over as broad a membership base as possible, so that the dollars are always available for those who are ill. The higher the premium, the fewer well people will join or stay on the plan, the result is adverse selection. As the plan's ability to spread the cost over the sick and the well erodes, costs per enrollee climb, and the plan eventually fails for lack of sufficient funds.

Second, since the highest cost component of delivering care is hospital services, it is critical to the success of any Medicare Risk plan that inpatient bed-days be managed with the utmost care. There are three keys to our success in managing our hospital costs: vertical integration (owning and operating primary, secondary and tertiary care facilities), provision of a drug benefit, and strong management systems. In the area with our largest concentration of Medicare members, California, FHP's hospital system is being expanded; FHP has purchased skilled nursing facilities; and has developed home health programs creating a continuum of care that allows the provisions of the appropriate level of care to meet members' requirements. By providing outpatient drugs to our enrollees for a nominal co-pay, there are no financial barriers to filling and taking the required medications. As a consequence we are able to keep our beneficiaries healthier and they are less likely to enter the hospital. Our management team, training systems and utilization review/quality assurance programs are very sophisticated.

Third, FHP has developed many programs which recognize the special needs of its senior members. For example, this winter, FHP's program includes special flu shot clinics targeting our senior members and other high risk groups. Simple things like providing an eyeglass benefit or extra large print on signs in our Senior Centers show our commitment to this population. Our experience shows that such efforts make a difference and, most importantly, increases senior access to timely, cost-effective care.

Earlier this year FHP, with the assistance of an outside actuarial firm, developed an analysis of the range of savings to the federal government and the beneficiaries for 1990. We calculated, based on a Medicare enrollment of 170,000, that the range of savings was $214 million to $255 million, derived as follows:

- FHP saved the federal government up to $35 million through the 5 percent difference between estimated fee-for-service costs and FHP's average payment rate or aggregate revenue from Medicare.

- FHP calculated that our Senior Plan members received an estimated $57 million worth of additional benefits -- like prescription drugs -- that are offered in addition to the regular Medicare benefit package. These benefits are preventative in nature, forestalling more serious and more expensive illnesses and representing an incalculable savings on medical care.

- FHP saved senior members an estimated $122 million to $163 million in

Medicare Supplement premiums this year, based on a basic policy offered by AARP and/or Blue Cross Blue Shield of an estimated $60 to $80 per month. Even those seniors who could not buy Medicare supplement coverage saved an average of $800 per year by not having to pay the standard Medicare Part A and B deductibles, coinsurance and balance billing.

While a similar calculation has not yet been undertaken for the 1991 contract year, savings would be expected to exceed $277 million.

Quality

If there is one touch stone of concern, it is whether or not the plans participating in the program provide the appropriate level of quality health care. Notwithstanding anecdotal examples of inappropriate care in both the fee-for-service and managed care sectors, FHP would respectfully submit that there are more incentives to provide proper care and review in a managed care setting than in the fee-for-service sector.

Managed care quality assurance systems are subject to extensive federal peer review of both inpatient and outpatient care, state certification procedures and HCFA qualification processes which require extensive formal and ongoing internal monitoring and assessment systems. Further, managed care plans subject each provider to a credentialing process designed to verify all degrees, licenses, malpractice experience and board certification. In the fee-for-service sector, a senior may make a provider choice with no certainty as to the basic qualifications of that provider. It cannot be emphasized frequently enough that as managers of delivery systems, Medicare Risk contractors place a priority on quality assurance because the alternative, inattention to quality, will be extraordinarily costly in terms of inappropriate care, under-service and result in high healthcare costs and malpractice, not to mention the eventual loss of business. As referenced earlier, this is borne out in several recent studies which state that the quality of health care provided in managed care programs is equal to or for some conditions exceeds that provided in the fee-for-service sector.

Managed care plans also provide two additional services that are often lacking in the fee-for-service sector – access and continuity. In general, risk contract enrollees have lower than average incomes and sometimes cannot afford supplemental coverage. As a result many, prior to enrolling in the managed care plan, have had little or no regular medical care, because they could ill-afford the deductibles or balance billing. If they have required care, it has usually been provided on an acute/emergency basis by a specialist assigned by the hospital. Continuity of care and basic health status suffers as the patient is referred to other providers without thought to coordination of care or acknowledgement of any social needs. In contrast, new enrollees in FHP and other managed care programs often are, for the first time in their lives, provided with low cost wellness care, continuity of care, and protection from catastrophic health care costs that they simple could not afford under the fee-for-service Medicare system.

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Consumer Satisfaction

By and large, consumer satisfaction with their Medicare Risk contract coverage is very high as evidenced by the recent Gallup Poll.[2] Unfortunately, cases of misunderstanding of benefits and difficult or complex resolution of isolated cases make it appear that the majority of consumers risk victimization by staying in the plans. In reality, these cases comprise only a minute fraction of one percent of the total program enrollment, even in areas with high managed care market penetration. In the vast majority of cases, usually misunderstandings of the lock-in provision (the requirement that members receive their care from plan providers), problems can be easily resolved with no financial harm to the beneficiary. Most importantly, the beneficiary has the option to disenroll almost at will either through the plan, their Social Security office, or through HCFA. Plans are continuing to improve their marketing systems and HCFA's ability to monitor plan activity and provide data on beneficiary inquiries has improved over time. Not only must plans' marketing material be approved by HCFA, but in many instances the state regulators review the material as well.

For the majority of beneficiaries, Medicare risk plans offer more benefits than fee-for-service, a choice of providers, freedom from the cost of supplemental Medicare policies, the elimination of balance billing by physicians and other providers, wellness and social service programs, the elimination of confusing paperwork and peace of mind.

The Future of Risk Contracts

The most challenging problem facing the Medicare Risk program today is dispelling the notion that plans are over-paid because the beneficiaries enrolled are generally younger and healthier. This notion is an artifact of studies undertaken during the early demonstration stage of the program, when some plans were allowed to health screen. In point of fact, the experience of most plans over time has been that enrollees have had little access to proper care prior to joining the plan and are therefore, sicker; and that the average age of a plan's participants increases and mirrors to a greater and greater degree the demographics and health status of the general Medicare population.

This change in plan demographics and several other factors have combined to erode plan payment rates and, if not corrected, will threaten the future of Medicare Risk contracts. This trend has been noted in two key studies:

- In a 1988 study for HCFA which was submitted to Congress, Milliman and Robertson noted that a 1987 error in Part B, "equals almost a 5 % error in total (Part A and Part B) program cost, making a 95% Adjusted Average Per

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[2] The Gallup Organization, "A National Survey of U.S. Health Plan Consumers," Final Report, May 1991.

Capita Cost (AAPCC) more like a 90% AAPCC."

- In February 1991, the Urban Institute released a report stating: "every 10 percentage points of HMO market share decreases Medicare expenditures by 1.2 percent in the short run and as much as 3.9 percent in the long run." In time a successful Medicare risk program creates a competitive environment which will ultimately insure its exit from the risk contracting marketplace.

In effect, the current payment system has created a mechanism under which managed care, by controlling costs in a market and by imposing competitive efficiencies on fee-for-service, causes its own payment rates to erode. Failure to address this basic conundrum has already threatened the viability of the program and forces plans to abandon their Medicare risk programs or to hold back on the growth of the programs.

FHP urges the Chairman and the members of the Subcommittee to support revision of the plan payment system in a manner which more accurately reflects the actual costs of providing health care. HCFA has already received input from the industry on corrections to biases created by not allowing for the impact of the working aged, the impact of end stage renal disease patients, miscalculation of the impact of Medicaid revenues, and potential problems with the Part A claims data, among other technical issues. Congress should urge speedy corrective steps in theses areas for the near term and formulation of a better methodology for the longer term. FHP and the industry have already provided HCFA will several options for consideration.

There are additional obstacles which effect program growth and beneficiary access to the risk contracts. One issue in particular has been of long-standing concern to FHP; the application of the 50/50 rule. In the absence of enrollment flexibility, beneficiary access to Medicare risk programs is limited or restricted in an arbitrary manner. In some areas demand for these programs is high because consumer satisfaction and quality is high and yet plans are forced to limit enrollment because of the 50/50 rule.

In the absence of a more appropriate standard, the rule has become an arbitrary proxy for quality of care. FHP would encourage the Subcommittee to consider replacing the rule with a more meaningful system of quality assurance. For example, multi-state plans should be permitted to apply the 50/50 rule over the Company's entire enrollment. Or, as an alternative, Congress should allow plans in areas with a higher concentration of seniors, to qualify for a 60/40 or 75/25 composition ratio (seniors/commercial) if the plan or its parent met certain basic quality assurance, financial, and operational experience criteria. Since the rule is predicated on protecting the levels and quality of health care, plans could be required to provide regulators with specific data on encounters and services provided in order to qualify for a variance from the 50/50 rule while assuring the appropriate levels of quality.

Further, there is a precedent for waivers from the strict application of the 50/50 rule.

Over the years Congress has allowed certain Medicaid plans to apply the rule on a 75/25 basis and has permitted other Medicare enrollment composition waivers without imposing any further or substitute standards for assuring quality. If these types of waivers are acceptable, then establishing a mechanism to qualify for Medicare composition waivers with more specific standards should also be acceptable.

In closing, much discussion has centered on HCFA's ability to assure plan compliance with the basic Medicare regulations and whether or not federal regulators have been granted sufficient authority to implement the regulations. FHP would respectfully submit that as the program has matured so has HCFA's ability to identify and regulate plan conformance with the program's requirements. Any further regulations, sanction authority, or compliance flexibility would be redundant and unnecessary.

Thank you for your consideration of these comments. FHP appreciates the opportunity to present our views to the Subcommittee.

FHP Contact: Janet G. Newport
(202)223-5718

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

January 21, 1992

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Congressman Waxman;

In a letter of December 6, 1991, you requested us to respond to questions posed by Congressman Richardson for the record of the hearing of November 15 1991, at which we testified. Our response is attached.

If you or Congressman Richardson have any questions regarding our response, please do not hesitate to contact Edwin Stropko of my staff at (202) 426-0843.

Yours sincerely,

Janet Shikles

Janet Shikles, Director
Health Financing and Policy Issues

Enclosure

Responses to Congressman Richardson's questions to GAO for the Record of the Nov. 15 hearing on HCFA's oversight of Medicare HMOs

1. Did GAO look at Medicare beneficiary satisfaction with the Medicare programs as a part of the study?

Response:

No. Our study focused on HCFA's oversight of the risk contract with Humana Medical Plan in Florida. However, the HHS OIG did conduct such a survey of Medicare HMO enrollees in Florida as a part of its study. The OIG found that enrolled beneficiaries were for the most part satisfied, and that marketing abuses were not widespread. However, a substantial minority (15% of those interviewed for Humana-Miami) felt that services were worse than those received from their previous source of care. Also, there was evidence of occasional unethical marketing practices.

2. Did GAO evaluate how many beneficiaries disenroll from one HMO only to enroll in another.

Response:

No. However, the HHS OIG performed such an evaluation as part of its study. The OIG found that a high proportion of beneficiaries who disenrolled from 4 HMOs (excluding Humana Medical Plan) in the Miami area enrolled in another HMO. This was not true for Humana, where only 19% of disenrollees enrolled in another HMO. However, the findings for Humana and the other 4 HMOs were not comparable because of Humana's much wider marketing area.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB 3 1992

The Honorable Henry A. Waxman
Chairman, Subcommittee on
Health and the Environment
Committee on Energy and Commerce
Washington, D.C. 20515

Dear Henry:

As you requested, I am enclosing my response to questions posed by Congressman Richardson following the November 15 hearing on the Medicare HMO Risk Contractor Program. I have also sent a copy to Congressman Richardson.

Please let me know if I can provide you with any additional information on this program.

Sincerely,

Gail R. Wilensky, Ph.D.
Administrator

Responses to Congressman Richardson
HMO Risk Contractor Program

1. **The Urban Institute recently came out with a study which shows that as HMOs successfully constrain the rate of medical cost in an area, HCFA's rate methodology reduces the payments Medicare risk contractors receive. HMO's success wind up penalizing the program. How does HCFA plan to eliminate this effect?**

   The law provides that HCFA make a payment to an HMO based on 95 percent of what it would have cost if the enrollee were not enrolled in the HMO. The law thus requires that the payment be made based on the cost in the fee-for-service sector. One of the goals of managed care is to constrain rapid increases in health care costs. If competition helps constrain the growth in health care costs in the fee-for-service sector, then all AAPCC payments must, appropriately, increase less rapidly.

   However, we recognize that the AAPCC payment rate is an issue of substantial concern, particularly in areas where HMOs have established a high market share. We are considering options that address the "penalty" effect on HMOs in these situations.

2. **What are HCFA's plans to improve the Medicare risk contract payment methodology? When will HCFA report recommendations on the rate improvements to Congress?**

   We continue to work to improve methodology and data collection to provide accurate AAPCC payments. Specific projects include an examination of the working aged issue. HCFA is looking into the feasibility of using the SSA-IRS data match to identify individuals who are subject to the Medicare working aged provisions. We hope to set a separate payment cell for the working aged. An additional initiative to improve the accuracy of the current payment methodology is the President's FY 92 budget request to establish an outlier pool for catastrophic costs.

3. **How many HMOs are terminating their Medicare risk contracts for 1992? What is the main reason given for these terminations?**

   Eleven risk-based contractors are nonrenewing their contracts for 1992: four are converting from a risk-based contract to some form of cost contracting with HCFA and will continue to provide care to Medicare beneficiaries; seven are withdrawing from the program entirely.

   The seven risk-based contractors which are leaving the Medicare prepaid health plan program have a Medicare

enrollment of 13,000, which represents only 0.9 percent of the total Medicare risk enrollment. All but one of these nonrenewing plans have less than 3,000 members, with an average plan size of 1,379 Medicare enrollees. One additional HMO is reducing its service area by one county, which will affect 700 Medicare enrollees.

Of these seven plans, three cited financial losses or low Adjusted Average Per Capita Cost (AAPCC) rates as the reason for nonrenewal, one plan was unable to attract a significant number of enrollees, and three plans did not provide a reason for nonrenewal.

In addition, during the course of the 1991 contract year, HCFA and two HMOs agreed to terminate their contracts mid-year because the HMOs ceased doing business.

HCFA received 24 applications for risk contracts during fiscal 1991; 13 plans applied for new contracts, while 11 applied for expansions. Nine of these applications were approved, while two were denied. Three plans withdrew their applications and the remaining applications are still pending.

4. When these plans terminate, do they leave the Medicare program entirely or do they switch to another type of contract?

As mentioned in the previous question, seven risk-based contractors are leaving the program entirely. Four additional risk-based contractors with 15,971 Medicare enrollees are converting to either a cost-based contract under Section 1876 of the Social Security Act, or a Health Care Prepayment Plan (HCPP) agreement. One of the four plans is only converting one county in its service area with the other counties remaining in risk. These four "conversions" represent less than half of the number of plans that converted last year.

Risk-based contractors that switch to another type of contract are required to provide appropriate, HCFA-approved notice to members. HCFA assures that the plan meets all nonrenewal requirements, such as providing or arranging for supplemental coverage with no health screening or waiting periods.

5. As you know the 50/50 rule requires plans to enroll no more than one Medicare or Medicaid enrollee for each commercial enrollee. This is intended to be a proxy for quality in the Medicare risk program whereby the employers in effect are used to assure that appropriate health care delivery systems are in place. Is this essentially correct?

Why don't retirees who enroll in Medicare risk contract programs through their employers' health benefit plan count as

commercial enrollees, since they have the same kind of protection all other commercial enrollees receive? Would HCFA support such a regulatory interpretation?

Your statement about the 50/50 requirement is essentially correct. This statutory requirement is intended to assure that organizations which contract with HCFA are of sufficient quality to attract commercial enrollees. HCFA reviews the health services delivery networks of Medicare-contracting HMOs to verify that the delivery systems that service Medicare are also used to serve commercial enrollees. In addition, the conference report language accompanying the enacting legislation indicates that the requirement was to ensure that the organizations remain financially sound.

Current law requires that half of the membership in a Medicare-contracting HMO not be eligible for benefits under Title XVIII or XIX of the Social Security Act. Therefore, HCFA would not support an interpretation that would permit retirees enrolled in a Medicare-contracting HMO through their employers to be counted as commercial members for the purposes of 50/50. These group enrollees are required to be Medicare-eligible to join the plan and therefore count as Medicare enrollees. That these members are enrolled through their employer does not negate their Medicare eligiblity, which is the determining factor for how they are counted for 50/50.

HMO PATIENT ADVOCATE COMMITTEE
P.O. Box 636102
Margate, FL 33063

December 16, 1991

Henry A. Waxman
Chairman, Subcommittee on Health and
Environment
U.S. House of Representatives
Committee on Energy and Commerce
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

In response to your letter of December 6th, 1991, we submit the following answers to the questions posed by Congressman Richardson.

ANSWERS TO QUESTIONS FOR ADVOCACY WITNESSES:
1. Our Committee has not addressed fee for service issues. However, the professional members of the Committee who work with Medicare recipients receiving their medical care in the fee for service sector, have seen the following problems:
A. Doctors billing Medicare for tests not performed. This abuse has increased since patients are no longer required to sign the bill for each test or consultation ordered.

B. Hospital inpatients may have only the briefest of visits by consulting specialty physicians when Medicare is being billed for full consultation services.

C. Hospital inpatients may be subjected to many unnecessary tests and consultations unrelated to the reason for hospitalization.

2. An invitation was extended to Humana through a second party to attend our meetings and they did not respond. For specific patient problems the HMO's generally responded although much follow-through was necessary on the part of the patient advocate.

3. Most members of our Committee are HMO patients. Our personal experiences have shown some of the following problems:

A. Inability to get a timely appointment with primary care physician.

B. Long waiting lines in clinics and doctors offices.

C. Inappropriate treatment of patients, i.e. cancelled appointments without notifying the patient; patients not accorded the dignity and respect mandated by law and medical ethics.

D. Unreasonable delay in referrals for tests and specialty consultations.

E. Medical decisions being made by administrative personnel.

4. In our experience the HMO's are not following Medicare guidelines in providing legally required level of service. The additional benefits offered are often difficult to obtain, are advertised in such a way as to mislead the prospective patient, or are offered in such a manner that it causes hardship for the patient to obtain these services.

In summary, we would refer you again to some of the case histories we submitted which we feel reflect a pattern in the way the Medicare-HMO patients are treated.

We thank you again for giving us the opportunity to participate in these proceedings and look forward to hearing from your committee again as regards any consequences or outcome.

Sincerely,

Sylvia Torgan

Sylvia Torgan, President
HMO Patient Advocate Committee
6237 Old Court Road
Boca Raton, FL 33433

Statement of

HUMANA, INC.

Humana Inc., based in Louisville, Kentucky, owns and operates 80 hospitals and has 1.7 million members in its health benefit plans for groups and Medicare recipients. Humana's health plans contract with 390 hospitals and 20,000 physicians across the country. As the nation's largest Medicare Risk contractor, Humana appreciates the willingness of the subcommittee to focus attention on the Risk program. The Medicare Risk program was established in 1982 to provide Medicare beneficiaries the same opportunity for enrollment in HMOs as exists for the under-65 population. Currently 93 HMOs contract with the government under this program and enroll nearly 1.4 million Medicare beneficiaries.

The Humana Gold Plus Plan has been in operation since 1987 when Humana Medical Plan acquired the bankrupt assets of International Medical Centers (IMC). Humana inherited approximately 115,000 Medicare Risk members when it took over IMC. In four years Humana Gold Plus Plan membership has grown to over 240,000. This growth would not have been possible without Humana's commitment to providing high quality care.

QUALITY MANAGEMENT PROGRAM

After the purchase of IMC, Humana initiated its Quality Management Program to assure quality of care for all members. This program includes periodic and systematic review of ambulatory, outpatient, inpatient and skilled nursing cases among Humana Medical Plan members,

including review of all mortalities in an inpatient or skilled nursing setting. Intensive review is undertaken on any case in which the quality of care is called into question. This review can lead to intermediate sanctions by the plan, such as the placement of the plan physician on a corrective action program or to termination of the physician's contract with the plan.

In 1989 Humana developed reports to monitor physician practice patterns. An interdisciplinary committee was created to measure and evaluate physician performances. In addition, each plan office has an active quality assurance committee that meets on a regular basis to review quality issues and recommend appropriate action. In the four Florida Medicare HMO markets, the quality management program includes a staff of 40 full-time nurses, eight full-time physicians and dozens of support personnel in the related area of customer service.

Humana established a rigorous credentialing process for every new health plan physician. For each new physician, the medical plan checks with at least three references, assures board certifications, examines past hospital affiliations, and checks medical school records. New physicians must be approved by health plan medical directors as well as by physicians on a credentials committee. Physicians also must be recredentialled after two years, a process which involves performance reviews by our quality assurance department.

MARKETING CHANGES

In January 1991, HCFA accepted Humana's corrective action plan designed to improve the marketing of the Humana Gold Plus Plan. Major enhancements included:

1. The sales manual for sales representatives was rewritten to insure appropriate marketing practices. A new manual was approved by HCFA for use by all Humana Medicare HMO plans. The entire sales force and sales management were retrained immediately following HCFA's approval of the new manual.

2. Sales representatives are required to undergo an investigative background check, follow a Code of Ethics, agree to fully explain the Lock-In Provision to every beneficiary, and agree to use only approved marketing materials. Violation of these steps will trigger disciplinary action up to and including termination and notification to federal and state regulatory and licensing bodies.

3. Humana does not process any application until the beneficiary positively confirms his or her intent to enroll. The verification process includes up to six efforts in contacting the beneficiary from point of sale to

new member orientation. These repeated contacts are made to assure that the beneficiary understands rules and benefits and to determine if a family member needs to know that the beneficiary has joined a Medicare HMO.

4. Agents are not allowed to sell door-to-door, but must make pre-set appointments. Humana reviews agent disenrollment patterns monthly and commissions are paid to agents, but the enrollee must remain with the plan 90 days for the commission kept.

The most recent HCFA site visit, conducted after the corrective action plan had been in place for several months found that all requirements for marketing compliance were met.

BENEFITS OF PROGRAM

The Humana Gold Plus Plan provides members with more benefits than Medicare can cover. The enrollee receives all the required basic Medicare services plus supplemental benefits including immunizations, physicals and screening tests, eye care, ear exams, dental care and prescription drug coverage. Other benefits include the elimination or reduction in copayments, the elimination of deductibles, and little or no time-consuming paperwork.

For seniors on a fixed income the Medicare Risk program provides an opportunity for members to receive benefits they might not otherwise be able to afford.

The Medicare Risk program costs the government 5 percent less than its own estimated fee-for-service costs to provide health care services to the same population. The Urban Institute recently reported that communities where there is increased penetration of Medicare HMOs, the cost of all health care decreases, causing the governments expenditures per Medicare beneficiary to decrease.

CUSTOMER SATISFACTION

One important measurement of the Humana Gold Plus Plan's quality is evident in the survey results we receive periodically from the Gallup Organization. The most recent independent survey conducted by Gallup showed a 93 percent customer satisfaction rate for our Medicare HMO members in Florida. Detailed responses in this survey show overall beneficiary satisfaction with the quality of care given by primary care physicians and hospitals that serve plan members, and similar satisfaction with the cost and access facets of the plan. The 93-percent positive rating is similar to results obtained from previous Gallup surveys, and conforms to the levels disclosed through our own survey results.

In addition to the Gallup surveys, a survey by the Wirthlin Group showed that 92 percent of members surveyed said that the sales agent thoroughly explained the plan and how it works. More importantly 86 percent of members would recommend Humana's Medicare HMO plan to a friend or relative.

The Medicare Risk program has demonstrated its ability to save money for taxpayers and beneficiaries. Its popularity among senior citizens testifies to its comprehensive benefits, its rigorous quality assurance and its responsive customer service. Humana maintains an abiding commitment to uphold the value of this important Federal initiative.

Contact persons: Tom Noland
Vice President-Communications
(502) 580-1804

Julie Goon
Director, Federal Relations
(202) 429-2015

Statement by PacifiCare Health Systems
to the Subcommittee on Health and the Environment
Committee on Energy and Commerce
November 15, 1991

PacifiCare Health Systems, Inc. (PacifiCare) is a publicly held health benefits company with health maintenance organization operations in California, Oklahoma, Oregon, Texas and Washington. PacifiCare currently serves the health care needs of approximately 2100 employer groups and more than 710,000 members. Secure Horizons, a program offered through our operations in California, Oklahoma, Oregon and Texas, currently provides more than 161,000 Medicare beneficiaries with affordable, comprehensive benefits.

We are especially proud of the Secure Horizons plan and appreciate the opportunity to go on record to explain why.

Secure Horizons receives 95% of 80% (less deductible) of the real costs of health care to seniors and provides 100% of cost of this care less small co-payments and provides preventive health care (annual physicals), Vision Care (glasses), Prescription Drugs (in some markets), respite care and eliminates the deductibles and coinsurance for medicare beneficiaries. Premiums are either zero or very minimal depending upon the AAPCC payments in those geographic areas. The cost savings to both HCFA and beneficiaries is substantial.

Marketing to Seniors:

We, at PacifiCare, believe strongly that in order to continue to successfully grow Secure Horizons, our Medicare risk program, we need to be very committed to educating our membership on all aspects of the Secure Horizons program. Our strong commitment to educating the senior population is integrated into our marketing strategy, as well as our member education program.

Our approach to marketing the Secure Horizons program is educational and includes inviting Medicare beneficiaries to group meetings supported by a toll-free telemarketing line for any questions that a senior may have prior to joining our program. We have developed slide presentations and a video that assist the marketing staff in fully explaining the Secure Horizons program to Medicare beneficiaries.

We, at PacifiCare, take many steps to ensure we are representing Secure Horizons as accurately and completely as possible. First of all, our field sales and telemarketing staffs are trained in all aspects of the program including the enrollment process, member service procedures and the grievance and appeals process so that they have a complete understanding of the program. Secondly, each Secure Horizons sales staff member is required to sign the Secure Horizons Code of Ethics. In so doing the Secure Horizons staff member is agreeing to represent Secure Horizons with honesty and integrity and agrees to adhere to a list of principles, including "making the needs of my prospect a priority". A copy of the Secure Horizons Code of Ethics follows this statement.

Another important step that Secure Horizons has taken to ensure that the program is properly represented is the development of the Secure Horizons Guarantee, which is included with all of our enrollment packets. The guarantee indicates that Secure Horizons is committed to maintaining its reputation as a quality organization and the staff has signed a Code of Ethics that they vow to represent Secure Horizons with honesty and integrity. In summary, the guarantee concludes that if the beneficiary's experience does not reflect this, he or she should write directly to the President of Secure Horizons who will investigate the situation personally. The guarantee is another commitment on part of Secure Horizons to educate and inform beneficiaries about the program and to live by its Code of Ethics. A copy of the guarantee follows this statement.

Another step Secure Horizons has taken to ensure that it properly presents the entire program to potential members is member involvement. Secure Horizons has selected and trained a group of Secure Horizons members who assist the staff in its marketing efforts. A member standing up at a sales presentation talking about his or her own personal experience with

utilizing the Secure Horizons program is often more credible and believable than a staff person who has not "lived" the program.

Another important step in our sales process is the enrollment verification call. Once a beneficiary has completed an application form to enroll in Secure Horizons, that application form is received by a separate and distinct enrollment staff who review it and call each and every prospective member prior to officially enrolling him/her in the Secure Horizons program. The enrollment staff which is not financially motivated to enroll members makes every effort to make sure that each prospective member is fully knowledgeable as to how to use the plan, and what is covered by the plan. Only after this enrollment call is completed, is the enrollment form officially processed.

Secure Horizons is also supportive of the efforts the Health Care Finance Administration, Group Health Association of America and American Association Retired People have taken to help educate prospective members about the Medicare risk program.

HCFA has developed an excellent video as well as a brochure entitled "Medicare and Coordinated Care Plans", which present the Medicare risk program in a fair manner as an option for beneficiaries to receive their Medicare benefits. In addition, GHAA has developed marketing guidelines, as well as a brochure entitled "Helping Older Adults Make Informed Decisions About Joining an HMO", which we at Pacificare assisted in developing and which are also utilized by Secure Horizons and many of the Medicare risk programs. In addition, AARP has several booklets available such as "More Health for your Dollar" and "Choosing an HMO", which that Secure Horizons utilizes in marketing the program. Again, presenting factual information about making a choice to join an HMO benefits the government, the health plan and the Medicare beneficiary.

In summation, in order for the Medicare risk program to successfully grow throughout the nation, it is imperative that Secure Horizons and all the Medicare risk contractors be sensitive to the Medicare population we are targeting by marketing our programs in an educational, ethical manner.

Quality Assurance Issues:

Of course, once a Medicare beneficiary enrolls in Secure Horizons, quality of care and beneficiary satisfaction are of paramount importance to our plan. We do not agree with the view that the 50/50 rule is an adequate measure of quality of health care. It is our view this regulatory restriction should only be utilized for new programs not experienced in program growth. Seasoned HMOs' with substantial commercial population, proven quality performance and maturity should be incentivized to enter new markets with any enrollment mix that makes good business sense for that geographic location. This rule, which was first passed in the 70's to force new HMO,s to enroll commercial members along with Medicaid and Medicare, has outlived its usefulness and should be replaced with a more mature approach to Quality Assurance. Commercial Enrollment in HMO's/CMP's exceeds Medicaid and Medicare enrollment percentages in organized delivery systems and inappropriate regulations only impede increased enrollment of both Medicaid and Medicare beneficiaries. The cost to government of not having greater enrollment is significant.

Industry experience with PRO-REVIEW has been very unsatisfactory to all entities even the PRO-REVIEW staffs'. This program needs to be replaced by strengthening and licensing the internal quality assurance programs of organized delivery systems. Once a program has been officially licensed to provide a high level of quality it should be required to report certain agreed upon data quarterly and also pay for annual independently conducted membership satisfaction surveys'. This twofold data reporting approach would move the industry toward providing clinical data to establish a continuous quality improvement process in each health care delivery system. Congress and HCFA should work with industry leaders to develop Managed Care Quality Assurance programs which will ensure beneficiaries receive the quality of health care they expect.

Even with the thorough education of beneficiaries regarding benefits and utilization of plan providers sometimes misunderstandings occur between health plans and Medicare beneficiaries. Secure Horizons adheres to the

HCFA regulations and interpretations on these issues and many times extends far above and beyond what is legally required to meet member needs. However, there are situations where miscommunication occurs and members are encouraged to utilize the appeals process when appropriate to seek reevaluation of questionable cases. Any complaint regarding quality of care is referred to Medical Services Department where a thorough evaluation is conducted.

Annual membership satisfaction surveys are independently conducted by most quality programs like PacifiCare. Our latest results reinforce the importance of finding ways to incentivize the growth of quality programs. Some of our findings are listed below for your information.

As part of an ongoing member satisfaction tracking system, an independent research organization interviewed 500 Secure Horizons members at random by telephone in July through September, 1991 (150 in Oregon,150 in Texas, 200 in California).

** Of those interviewed who expressed an opinion:

+ 96% indicated that they were satisfied with their Secure Horizon health plan;

+ 96% indicated that they would be likely to recommend Secure Horizons to a friend; and

+ 94% indicated that Secure Horizons is either what they expected or better than what they expected a health plan to be.

AAPCC Payment Methodology:

Based upon recent research and empirical data it is important to establish predictability in payment methodology to reassure Medicare Risk contracting HMO s/CMPs that extensive efforts to control the abuses occurring in traditional Medicare programs through Resource Based

Relative Value Scale won't negatively impact this program. There are several reports which suggest the impact of RBRVS will reduce AAPCC payments below acceptable levels. Other reports indicate the inconsistencies in AAPCC payments between zip code areas may be due to flaws in the methodology which could be corrected. Some of these issues, listed below, which should be addressed by the proper institutions.

Working Aged, CHAMPUS, VA Adjustment:

The impact of high concentration of CHAMPUS, VA and Working Aged in specific geographic areas has an obvious effect upon reported HCFA costs and should be adjusted in payment rates of risk contractors.

Impact of HMO penetration on Geographic areas:

According to W. Pete Welch, "HMO Market share and its Effect on Local Medicare Costs", March 1991, the Urban Institute concluded that increased penetration of markets by HMO s will impact the rate of increase of health care costs. Adjustments to risk contracting plans could incentivize continued growth once a geographic area reaches a certain penetration level. If these adjustments are properly made, continued penetration will occur.

Medi-Gap Influence on AAPCC:

Recent studies reported in Inquiry (Fall 1991) show that Medi-Gap policy ownership has a substantial, positive impact on service usage and costs, particularly for beneficiaries in fair or poor health. This type of research suggests the lower AAPCC (rural markets) may be greatly underserved due to lack of access for seniors who have low fixed income and cannot afford Medi-Gap policies. Obviously many seniors either don't have the funds or providers are not available to provide services in many non-

urban areas. Congress should find ways to incentivize risk contracting plans to extend services to lower payment markets through rate adjustments. This is warranted since this recent study found ownership of group policies increased hospital expenditures by 30%.

In conclusion the Medicare risk program represents what congress intended by providing beneficiaries affordable comprehensive benefits. When properly managed, beneficiaries enjoy quality health benefit plans at affordable costs, Medicare spends significantly less than traditional Medicare and delivery systems are successful once they learn how to manage and provide health services in the same setting.

Carmen O. Ness, HSD
Vice President
Government Relations
PacifiCare Health Systems

CON:ls

Attachments

Attachment A

SecureHorizons

Health care for today's senior.

A DIVISION OF PACIFICARE®

SECURE HORIZONS CODE OF ETHICS

Secure Horizons, a division of PacifiCare Health Systems a leading Medicare Health Maintenance Organization, requires adherence to the following Code of Ethics for all company sales and marketing representatives. Embracing this Code assures the highest quality in promoting Secure Horizons by creating a fair, honest and competitive environment.

I, _____, as a representative of Secure Horizons agree to uphold the Vision of PacifiCare Health Systems which is "to improve the quality of those lives I touch."

I will represent SecureHorizons with honesty and integrity by adhering to the following

1. Make the needs of my prospect a priority.
2. Make no false or misleading statements.
3. Fully and accurately disclose all pertinent information for the prospect to make an informed decision.
4. Explain the program in such a way that my prospect clearly understands the following:
   - Lock-in feature
   - Disenrollment procedure
   - Benefits
   - Co-payments and premiums
5. Speak of competitors only in fair and factual terms not on rumors or hearsay.
6. Respect the confidentiality of privileged information that may come my way in the course of representing or selling Secure Horizons.
7. Will not discriminate because of race, color, religion, sex, national origin, physical handicap or otherwise.

I clearly understand the above statements and accept this Code of Ethics as my standard for conducting business while an employee of Secure Horizons.

_____ _____

Signature *Date*

Attachment B

We at Secure Horizons have worked hard to develop a comprehensive, low cost health plan. One that can meet the needs of a wide range of seniors.

the Secure Horizons guarantee

Our marketing people – those folks representing Secure Horizons to you – are committed to maintaining our reputation as a quality organization. Secure Horizons representatives have developed and adhere to a Code of Ethics in which they vow to represent Secure Horizons with honesty and integrity. Specifically, each Secure Horizons representative will:

- Make the needs of our customer (you) our highest priority.
- Make no false or misleading statements.
- Explain the program in such a way that you clearly understand all of the benefits, as well as its limitations and restrictions.
- Fully and accurately disclose all pertinent information in order for you to make an informed decision.

You should expect nothing less than complete honesty and integrity from us. If your experience does not reflect this, I want to know about it. Please write to me personally: Jeff Folick, President, Secure Horizons, 5796 Corporate Avenue, Cypress, CA 90630.

Sincerely,

Jeffrey M. Folick
President

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